Adhesion Pain Patient Questionnaire

Patient information
Name: ____ DOB: ________ Age: _______

Address: ____

Suburb: ____ Postcode: ____________

Phone (daytime) : _________________________________

Private Health Insurance provider: ____

Doctor that diagnosed you with adhesion pain: ___________________________________

What other health care practitioners or therapists have you seen for your condition?

____

____

Describe your pain, where is it, what does it feel like? ________________________________

____

-____

When and how often do you experience it? ____

____

What is the pain level on a scale of 1 to 10 (10 is the worst)? __________________________

What makes the pain worse? ____

Please list what medications, supplements/herbs and any therapies you are currently using:

Medications: ____

____

Supplements, herbs, natural therapies: ____

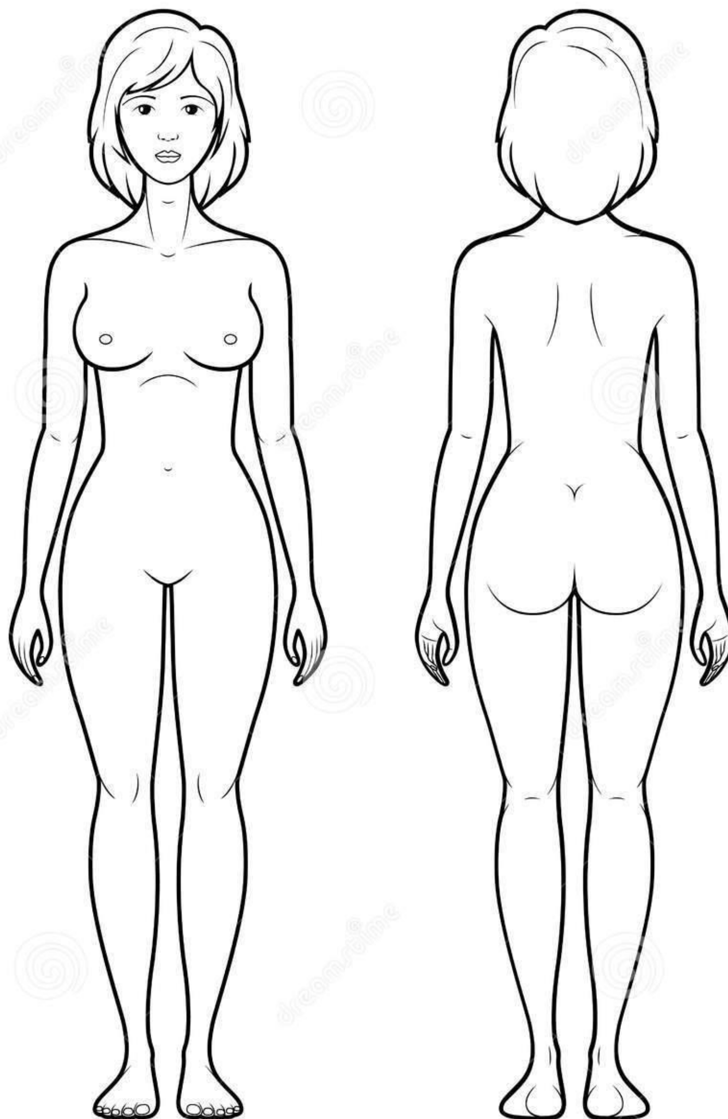
Have you had any surgeries? ___________________________ Please list them and when they occurred:

____

____

____

Please highlight or shade the areas where you experience pain. Also write the pain level on a scale of 1 to 10 (10 is the worst) in those areas.



How did you find us? ____

If internet, what did you search for? ____

Consent to Treatment & Privacy statement:

I request and consent to any bodywork or naturopathic therapies as found appropriate.
I understand that not all risks can be anticipated or explained by my practitioner.
I have had the opportunity to ask questions about the proposed therapy to my satisfaction.
I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

This information will only be used for record keeping purposes and will not be shared with a third party unless legally required or your consent has been received.

Signature ____ Date ______________

(Or guardian's signature if under 16 years old)