**Harding Physiotherapy Client Pre-Appointment Screening Form (26/07/2020)**

If you would like to book an appointment with us, please provide the following information so that we can consider if we can effectively support you remotely, or whether it is appropriate to discuss seeing you face to face. **All the information must be completed to be considered for an appointment**. Once our Therapists have reviewed your information, we will call you to discuss and confirm the booking. We are working within current guidelines from the CSP, Physio First and PHE, and will amend our booking process as these guidelines change.

**Your Contact Details**

**Name:**

**DOB:**

**Telephone number:**

**Email:**

**Appointment Preference** Remote (Via Zoom/Skype/Telephone)

Face to Face in clinic

Socially Distanced Outdoor (no hands on)

**Reason for your Preference**:

**About You (Please tick Yes/No for every question)**

**1.Are you in generally good health?** NO YES

**2.Have you been told by a Doctor that you should be shielding?** NO YES

**3.Have you had /do you have /are you undergoing any of the following? If YES to any please supply further detail**

An organ transplant NO YES

Chemotherapy or Antibody treatment for cancer NO YES

Radiotherapy for lung cancer NO YES

Targeted cancer treatments that can affect the immune system NO YES

Blood or bone marrow cancer NO YES

Bone marrow or stem cell transplant in the past 6 months NO YES

Lung conditions (such as Cystic Fibrosis, severe COPD, asthma, bronchitis) NO YES

A condition that makes you at high risk of getting infections (such as sickle cell)

NO YES

Taking medication that makes you more likely to get infections (such as steroids, or immunosuppressant medicine) NO YES

Have a serious heart condition or heart disease NO YES

Pregnant NO YES

Diabetes NO YES

Chronic Kidney Disease NO YES

Liver Disease (such as Hepatitis) NO YES

Neurological Conditions (such as MS, Motor Neurone Disease, Parkinson’s Disease) NO YES

Obese (BMI 40 or above) NO YES

**4.Do you have any medical conditions not listed above?** If yes please detail;

NO YES

**5.Do you take any medication?** If yes, what?

NO YES

**About your current Pain/Injury/Symptoms**

**Tell us about why you contacted us for an appointment**. Where is your pain? How and when did it start? Have you noticed anything that makes it feel better or worse? Does it affect your sleep/work/hobbies/daily life/ability to care for yourself or other dependants? The more detail you can give, the better please

**Have you been to the GP or Hospital with this pain/symptoms?** If YES, please detail

NO YES

**Other Questions**

**Are any other members of your household shielding?** NO YES

**Have you returned from abroad in the past 14 days?** NO YES

If YES, please detail where you travelled from, including any transit stops, and when

**Do you have any potential symptoms of COVID-19? (fever/temperature/continuous cough/loss of or change in taste or smell)** NO YES

**Do any of the members of your household have any potential** **symptoms of COVID-19? (fever/temperature/continuous cough/loss of or change in taste or smell)** NO YES

**Have you been tested as positive for COVID-19?** NO YES

If YES, please detail when the positive test was

**Has anyone in your household you been tested as positive for COVID-19?**

NO YES

If YES, please detail when the positive test was

**Date form completed;**

**Client Name/Signature;**

Thank you for taking the time to complete this form.

Please now return it to the clinic, and our Therapists will review it. We will then telephone you to discuss further and make a suitable booking for you.