MUSCULOSKELETAL PHYSIOTHERAPY SERVICE
PATIENT ASSESSMENT QUESTIONNAIRE/SELF REFERRAL FORM

Cornwall Partnership NHS
NHS Foundation Trust

Please complete **both** sides of this form before your Physiotherapy Assessment

Mr/Mrs/Miss/Ms/Dr/Other **Full Name:**	**Date of birth:**	**Gender: M F**

Full Address:……

……...

Telephone Numbers: Home:…….Mobile:……..

GP Name/Practice:……

NHS Number:……Ethnicity:…….

Who recommended that you have Physiotherapy: GP □ Consultant □ Self □ Other □

Do you work for CFT □ RCHT □ If so, how did you hear about this service?

Briefly describe your current problem, e.g. *knee pain, fractured ankle (please note exceptions: 1. If you have a back or neck problem please see your GP who may refer you. 2. Patients under 16 years of age must be referred by a GP).*
When did it start and how long have you had the symptoms?

How did it start?

Is your problem: Getting better □ Getting worse □ Staying the same □

Using a scale of 0-10, score your level of pain, where 0 is no pain and 10 is the worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Have you had any previous treatment for this problem? *(e.g. medical treatment, physiotherapy, osteopathy, chiropractor):* □ YES □ NO
If yes, please give details, including WHERE and WHEN:

Have you had any investigations for this problem? *(e.g. scans, X-rays, blood tests)* □ YES □ NO
If yes, please give details:

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Name: **NHS Number:** **Date of birth:**

Your general health – please tick if you have any of the following:

	YES	NO		YES	NO
Any major illness/health problem			Unexplained weight loss		
History of cancer			Rheumatoid Arthritis		
Diabetes			Epilepsy		
Heart problems			Pregnancy (current)		
Blood pressure problems			Any surgery/operations		
Chest/breathing problems			Previous fractures		
Steroids			Osteoporosis		
Anticoagulants			Any other joint problems		
Any bladder/bowel symptoms					

Please give details:

Please list any medications that you are taking or bring a print out of your current prescription:

What is your occupation?:

Please give details of any hobbies:

Are you: Off sick due to this problem □ Employed □ Retired □ Main carer □
Self-employed □ Unemployed □ Student □ Other □

What do you think is causing this pain and how do you think that Physiotherapy will be able to help you?

I……confirm that the information provided above is correct to the best of my knowledge. I give my consent to the physiotherapy assessment and treatment of my problem. *(This may be withdrawn at any time during this period).*
I am aware that I may be accompanied by a chaperone.
I am aware that I can ask for a copy of my letter
I give consent for a message to be left on my answerphone Yes/No

Patient signature……Date……
Are you completing this form on behalf of someone? Yes/No
If so please state your name and relationship to this patient
Name……Relationship……..