Headline

Physiotherapy for the Head, Neck and Jaw

Name of Patient.....Date of Birth.....

Address.....

.....

Telephone ..... Mobile .....

Email .....

Alternative Contact Person.....Tel.....

Referred by.....

Consent for Assessment and Treatment

Name of Patient:…….……

Physiotherapy assessment and treatment may include physical examination and the collection of detailed information. This is necessary for us to provide the highest level of care. You must inform your therapist if you are unsure or uncomfortable at any time, so the necessary explanation or adjustment can be made. Your involvement in the programme is imperative to its success.

Interventions may include manual therapy, exercises, education, ultrasound, taping, heat/cold application and acupuncture. It may be necessary to work inside the mouth. You must inform us if you have an allergy to latex, zinc oxide, nuts, bees, perfumes or any other substance.

☐ I understand the above policy and consent to a comprehensive physiotherapy assessment and course of treatment. I have the right to withdraw consent to any part of the treatment at any time.

Privacy Policy

☐ I have read the Headline Privacy Policy and understand how it applies to me. Any questions have been answered to my satisfaction. I agree to the collection and use of my information as set out in the Headline Privacy Policy. I am aware that I have access to this information and I may withdraw my consent at any time.

Billing and Cancellation Policy

Please notify us if you are unable to attend your appointment. We usually have a waiting list of clients willing to fill spaces. We require 24 hours notice of cancellation, either by phone, email or via our website, or the full fee will be charged. Cancellations made at short notice will not be charged if we are able to fill that appointment, so please let us know as soon as possible.

☐ I acknowledge that I am responsible for all charges incurred at Headline Physiotherapy and that if I am unable to attend I will give 24 hours notice or the full fee will be charged.

Please tick the boxes and sign below to indicate that you have read and accept the above consent and policies.

Signature of Patient…….**Date**:…….

(Or parent/guardian if under 18 or unable to sign) Name:……..……

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Physiotherapy for the Head, Neck and Jaw

Name : ……

Completing this form will assist your physiotherapist in assessing your condition. Please fill out the sections that are relevant to you. Ask a member of staff if you need assistance.

1. Primary Concerns (Pain, Lack of function etc)

2. What do you Hope to Gain From Treatment?

3. History of Current Condition

4. Dates of Surgery/Radiotherapy etc.

5. Other Medical/Dental History

6. Medications

7. Allergies

8. Names & Contact Details of Other Treating Professionals

Please complete the accompanying diagrams with details of your symptoms.

- Show areas of pain or headache and describe the type of pain.
- Give details of any tingling, numbness, or similar sensations.
- Show areas of stiffness and anything you feel may be relevant
- Pain on your right side should be shown on the side marked R.

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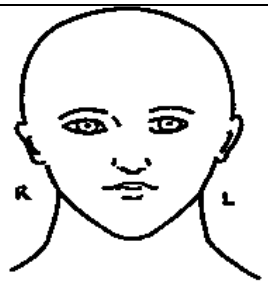
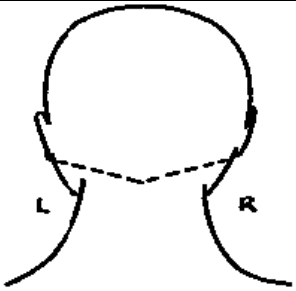
<td> 

Face</td>
<td> 

Head/Neck</td>
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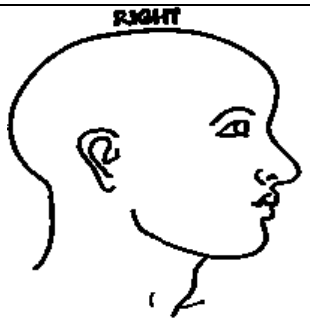
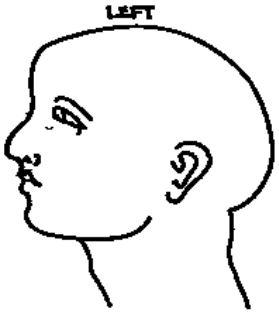
<td> 

Right side of Face</td>
<td> 

Left side of Face</td>
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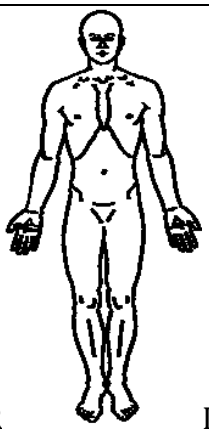
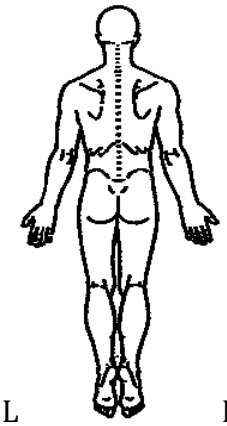
<td> 
R L
Body (Front)</td>
<td> 
L R
Body (Back)</td>
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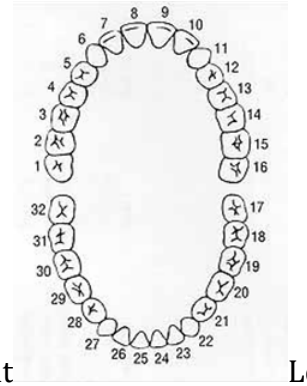
<td> 

Right Eye Left Eye</td>
<td>Teeth of Upper Jaw


Right Left
Teeth of Lower Jaw</td>
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</table>

CHI – Questionnaire

Name ……..

Date …… Score ……

Please **circle** the score, which most closely applies to your situation

1. I experience a problem involving my head, neck, face or jaw:

0	1	2	3	4	5	6	7	8	9	10
Not at all	Very Rarely		Occasionally		Regularly		Most days		Daily	Constantly

2. This problem restricts my everyday life:

0	1	2	3	4	5	6	7	8	9	10
Not at all	Very Rarely		Occasionally		Regularly		Most days		Daily	Constantly

3. In recent days, I would rate my **pain** as:

0	1	2	3	4	5	6	7	8	9	10
No pain at all										Worst possible

4. In recent days, I would rate my general **impairment** (ie difficulty with function, movements, concentration, sleeping, eating, talking) from this problem as:

0	1	2	3	4	5	6	7	8	9	10
No impairment										Total incapacity

5. In recent days, I would rate my **mood** as:

0	1	2	3	4	5	6	7	8	9	10
Happy, satisfied with life		somewhat down		very down		depressed		extremely depressed		

6. I withdraw from social activities because of my condition:

0	1	2	3	4	5	6	7	8	9	10
Not at all	Very Rarely		Occasionally		Regularly		Most days		Daily	Constantly

7. My work, study and/or home duties are affected by this condition:

0	1	2	3	4	5	6	7	8	9	10
Not at all	Very Rarely		Occasionally		Regularly		Most days		Daily	Constantly

8. I am worried that I do not fully understand my condition:

0	1	2	3	4	5	6	7	8	9	10
Not at all			Somewhat			Concerned			Very Concerned	