

## Michael James Lumb Biokineticist Patient Information Form

Please fill this form using capital letters and circle the multiple choice answers\*

Title:\* Dr/ Mrs/ Ms/ Miss \_\_\_\_\_

Name & Surname: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Mobile No: \_\_\_\_\_

Marital status: \_\_\_\_\_ Home: \_\_\_\_\_

Partners Name: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_ ID Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

\_\_\_\_\_ Code: \_\_\_\_\_

Postal Address: \_\_\_\_\_

\_\_\_\_\_ Code: \_\_\_\_\_

Medical Aid: \_\_\_\_\_ GP: \_\_\_\_\_

Medical Aid No: \_\_\_\_\_ Previous Biokineticist: \_\_\_\_\_

Referral Source\*: GP/ Previous Patient/ Facebook/ Instagram/ Other \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Contact number: \_\_\_\_\_

Allergies: \_\_\_\_\_

Any Chronic Illness, disease, surgery or hospitalisations: \_\_\_\_\_

\_\_\_\_\_

Current medication: \_\_\_\_\_

Are you here for\*: Pain Management or Health & Fitness assessment or Exercise Rehabilitation?

---

**Declaration:** (if patient id under the age of 16 parent/guardian to sign)

I, \_\_\_\_\_ (print name) hereby declare that the above information is correct, and the I undertake to settle my account immediately. By signing this declaration I hereby give my consent to receive Biokineticist treatment by Michael James Lumb.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_