Villene Alderslade
CECILIA SQUARE PAARL · FRANSCHHOEK
PHYSIOTHERAPY
SPORTS, SPINE & JOINT REHABILITATION
PR#7231520

Patient No

PATIENT DETAILS

Title Initials First Names

Surname

Birth Date ID No Preferred Language

Gender Female ☐ Male ☐ Passport No GP

Medical History

Reason for visit

ACCOUNT HOLDER

Title Initials First Names

Surname

Birth Date ID No Preferred Language

Passport No GP

Address

Postal Address

Postal Code

Cell No Home Tel Work Tel

Email May we contact you via email? Yes ☐ No ☐

MEDICAL DETAILS

Private ☐ Medical Aid ☐ Hospital Plan CFM ☐

Medical Aid Name Medical Aid No

Main Member Member ID No

EMERGENCY CONTACT

Name Surname

Relationship Tel No

Please sign for consent to evaluate and treat a minor.

Date Signature

For general information and detailed T&Cs please see overleaf. I agree to terms and conditions.

Date Signature

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GENERAL INFORMATION: Welcome to the Physiotherapy Practice of Villene Alderslade, based in Paarl and Franschhoek. The aim of this practice is to provide an excellent, caring and highly skilled physiotherapy assessment and intervention for your neuromusculoskeletal need. All associates working within this practice have participated in advanced training courses, have acquired advanced qualifications and participate in ongoing physiotherapy education programs.

Please review the following information provided and please sign at the end to acknowledge that you have read and understood how we would like to operate our Physiotherapy service.

TARIFFS AND MEDICAL AIDS: The HPCSA requires transparency with regard to billing procedures. This practice charges rates which are currently reimbursed by most South African Medical Aids. We will submit your account to your medical aid electronically if you provide us with the details. Payment is then directly into the practice account. Any shortfall is for your account and is to be settled immediately on request. The client is liable for all debt recovery costs. Please make a payment plan if required to avoid additional costs by non-payment. Interest on overdue accounts will be levied.

PRIVATE PATIENTS: Private clients are billed at a similar rate as medical aid patients/with the rate according to Discovery Health Medical Aid being our default rate. The account is due on receipt immediately. No credit facilities are offered. No discount is offered as our rates are already as economical as possible, with no differentials.

CONSULTATIONS: Appointments are typically 40 minutes in duration. Evaluations which are complex or involve more than one area may require additional time, or evaluation over two sessions, this will be billed accordingly, as two separate areas and sessions. Reports written for referrals, insurances, motivations or any form of report will be billed or as a separate fee.

CANCELLATIONS: Please advise the office as soon as possible to any necessary changes in booked appointments. This enables us to best fulfill all patient needs and provide an excellent service. Your co-operation is appreciated.

OFFICE HOURS: The Franschhoek office operates from 8:30am to 5pm Monday to Friday. The operating hours outside of this office, at Celia Square or home visits, vary according to the demand and availability of therapists to service those areas or fulfill those needs.

CONFIDENTIALITY: The practice is required by legislation to supply ICD10 codes to medical aids, all our accounts have these descriptive codes present. Your diagnosis may need to shared with other practitioners or persons involved in your care. Please provide consent for the practice to release your diagnosis.

Please sign below to indicate that you have read and understood this information provided.

Date _____ Signed at _____ Signature _____

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Office 064 751 9958 or 086 110 6664 · physioatpearlvalley@gmail.com
Christelle de Klerk · 082 922 6655 · BSc Physio (OFS)

48 Village Artisan, Cabriére Street, Franschhoek 7690
Office 021 876 4234 · villenealderslade@gmail.com
Villene Alderslade · 083 282 1379 · B PhysT (Pret), M Physio (US)

MEDICAL SCREENING QUESTIONNAIRE

Villene Alderslade Physiotherapy,
Registered Physiotherapists

Please complete the questions below to assist your physiotherapist to compile a detailed medical history and background information. If you do not understand a question please leave it blank and discuss it with your physiotherapist. This document forms part of your physiotherapy record. **Thank you!**

Date: __ /__ / __ Patient Name: _____ Age: _____

Referred to physiotherapy by medical practioner? YES NO or SELF (please circle)

Current problem for which you are seeking advice: _____

_____

Allergies: if any, e.g. medications, latex, arnica oil, other: _____

Please circle: Smoker YES NO Pregnant YES NO Pacemaker YES NO

Please let us know who else is currently caring for you: list name and details:

Medical doctor (GP): _____ Date last visit: __ /__ / __ Reason: _____

Psychologist/Psychiatrist: _____ Date last visit: __ /__ / __ Reason: _____

Chiropractor: _____ Date last visit: __ /__ / __ Reason: _____

Physiotherapist: _____ Date last visit: __ /__ / __ Reason: _____

Other: _____ Date last visit: __ /__ / __ Reason: _____

Have you or do you experience any of the following? Circle or indicate YES or NO

Weight loss or gain	YES NO	Weakness	YES NO	Fever/chills/night sweats	YES NO
Malaise or fatigue/feeling unwell	YES NO	Drop attacks/fainting/syncope	YES NO	Difficulty breathing/cough	YES NO
Nausea/vomiting	YES NO	Dizziness/lightheaded	YES NO	Pain at night	YES NO
Numbness/tingling	YES NO	Sexual dysfunction	YES NO	Vision disturbances	YES NO
Difficulty balancing/walking	YES NO	Passing blood in urine/stool	YES NO	Difficulty speaking	YES NO

1. Have you ever been in an **accident or experienced violent trauma** (e.g. motor vehicle accident / domestic abuse / traumatic falls / other)? YES NO Description:
   _____
2. During the past 3 months, have you **felt down / depressed** or hopeless? YES NO
3. During the past month, have you had **little interest or pleasure** in doing things? YES NO
4. Have you ever taken or do you currently use **steroids or cortisone** as a medication? YES NO

Medications: Please list any medications you are CURRENTLY taking: _____

_____

Other medication you have recently taken or that has been prescribed: _____

_____

Please turn over to complete .../PAGE 2

MEDICAL SCREENING QUESTIONNAIRE cont.

Previous surgery or injuries: Please list any previous injuries or surgical procedures.

Date: __ /__ / __ Procedure / Reason: _____

Date: __ /__ / __ Procedure / Reason: _____

Date: __ /__ / __ Procedure / Reason: _____

Have you ever been diagnosed as having any of the following conditions? Give details if possible.

YES NO Cancer. Where, when? _____

YES NO Heart problems. If yes what kind? _____

YES NO High blood pressure _____

YES NO Circulatory disorders _____

YES NO Respiratory or chest problems / asthma _____

YES NO Thyroid _____

YES NO Diabetes. What type? When first noted? _____

YES NO Stomach problems. Describe _____

YES NO Chemical dependency (e.g. alcohol, medications, recreational drugs) _____

YES NO Neurological disorders (e.g. stroke, MS) _____

YES NO Arthritis. What type: rheumatoid or osteoarthritis? _____

YES NO Depression _____

YES NO Bladder or bowel problems _____

YES NO Blood clots. When, where? _____

Have YOU ever had or been diagnosed with any of the following conditions (circle):

Kidney disease / tuberculosis / hepatitis / HIV or Aids / epilepsy / mental illness _____

_____

Do any FAMILY members have any of the following conditions?

Diabetes / tuberculosis / heart disease / high blood pressure / stroke / kidney disease / alcoholism / cancer / arthritis / anaemia / headaches / epilepsy / mental illness

Previous conditions for which you have received physiotherapy: _____

_____

Any other medical or related history that you would like to report on that we may have omitted to ask in this questionnaire: _____

Villene Alderslade Physiotherapy,
Registered Physiotherapists

CONSENT FOR DRY NEEDLING TREATMENT

This document is to be read in conjunction with the information sheet titled "Dry Needling information"

1. I _____ (full name), in my capacity as:

   ☐ The patient ,
   Or
   ☐ The parent or legal guardian of the patient: _____ (patient's full name)
   who is my: Spouse/Child/Grandchild/Parent/Sibling/Foster Child/Ward (please circle the appropriate term)
   do hereby give my consent for the performance of dry needling therapy by the physiotherapist named _____

   at the physiotherapy practice/department of: _____

2. This consent is limited to the duration of the current series of treatments. I understand that I can withdraw my consent at any time. I understand that if I do withdraw my consent, I must confirm that I have done so in writing.

3. I understand the therapist is appropriately qualified and trained to perform the required therapy.

4. The areas of the body that I consent to have dry needled are:

   _____

5. I am satisfied that the technique has been fully explained to me, and that my concerns have been addressed and that my questions have been answered to my satisfaction. I have read the attached information sheet called "Dry Needling information", and am in a satisfactory position to weigh up the risks and limitations of the technique as regards known side-effects.

6. I understand that the technique is performed within a rehabilitative framework and that I must follow instructions as given by the physiotherapist.

7. I hereby indemnify the therapist and the practice against any and all liability arising from the treatment described above, including unforeseen or unknown consequences.

   Date: _____ Time: _____ Place: _____

   Patient: _____ Guardian/Mandated person: _____

WITHDRAWAL OF CONSENT FOR DRY NEEDLING TREATMENT

1. I _____ (full name), in my capacity as:

   ☐ The patient ,
   Or
   ☐ The parent or legal guardian of the patient: _____ (patient's full name)
   who is my: Spouse/Child/Grandchild/Parent/Sibling/Foster Child/Ward (please circle the appropriate term)
   do hereby **exercise my right to withdraw consent to treatment** as originally given to the

   physiotherapist _____

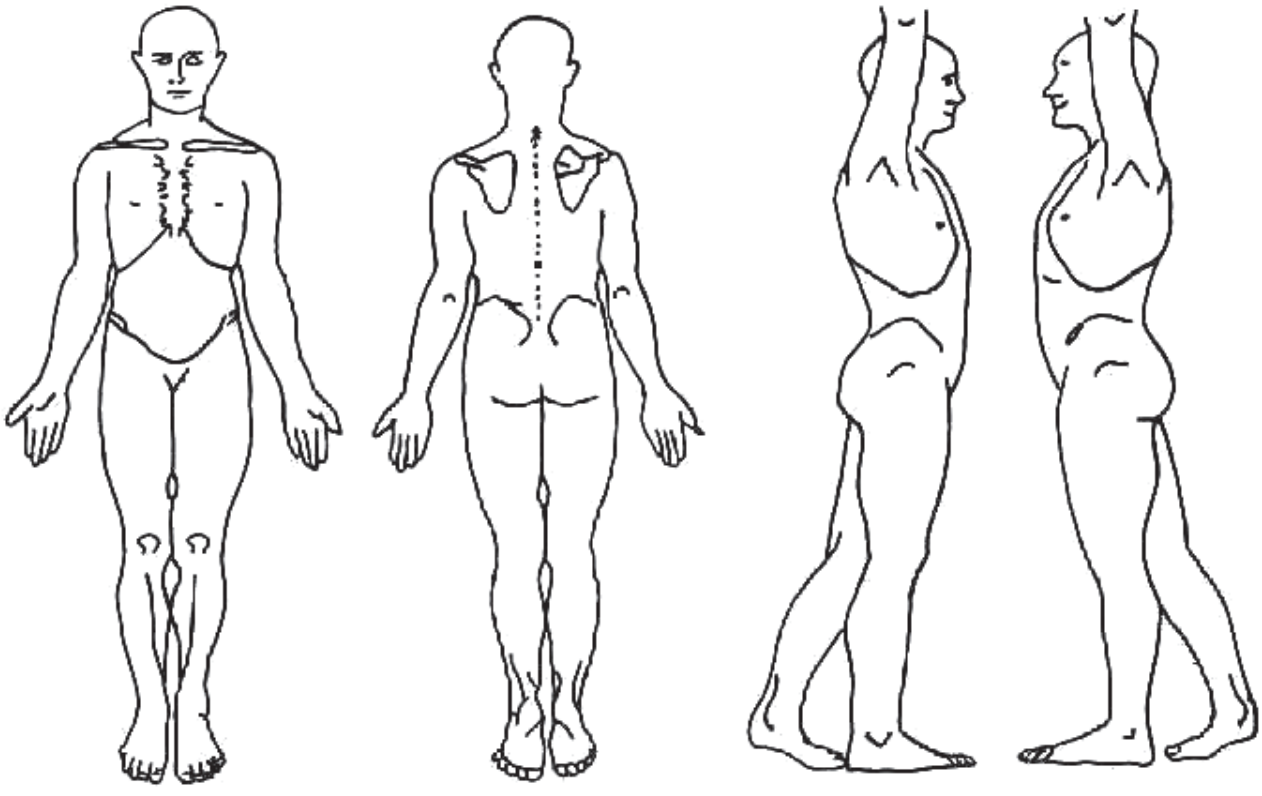
   at the physiotherapy practice/department of: _____

   Date: _____ Time: _____ Place: _____

   Patient: _____ Guardian/Mandated person: _____

Patient Name

Date

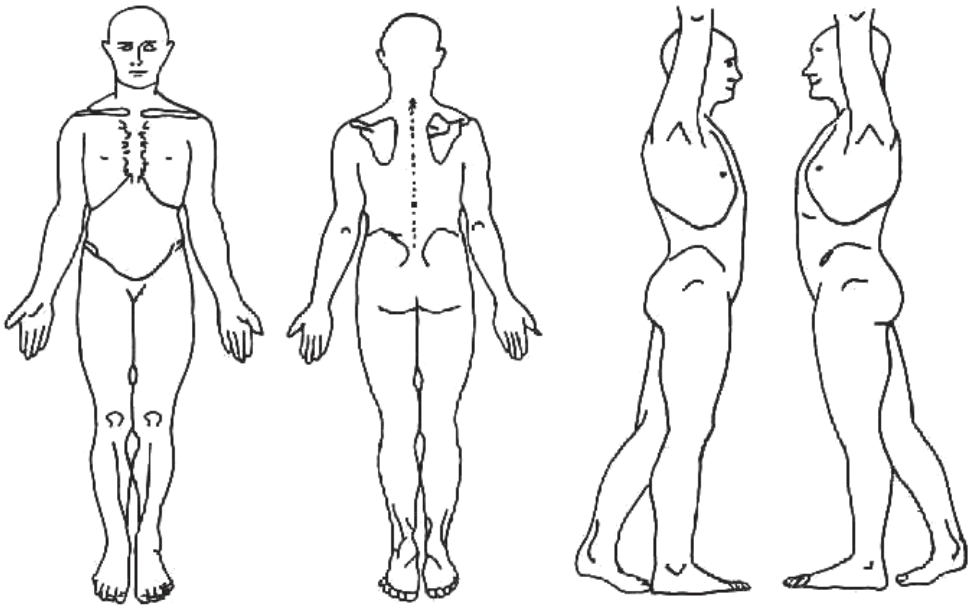


Diagnosis:

Treatment:

Patient Name

Date

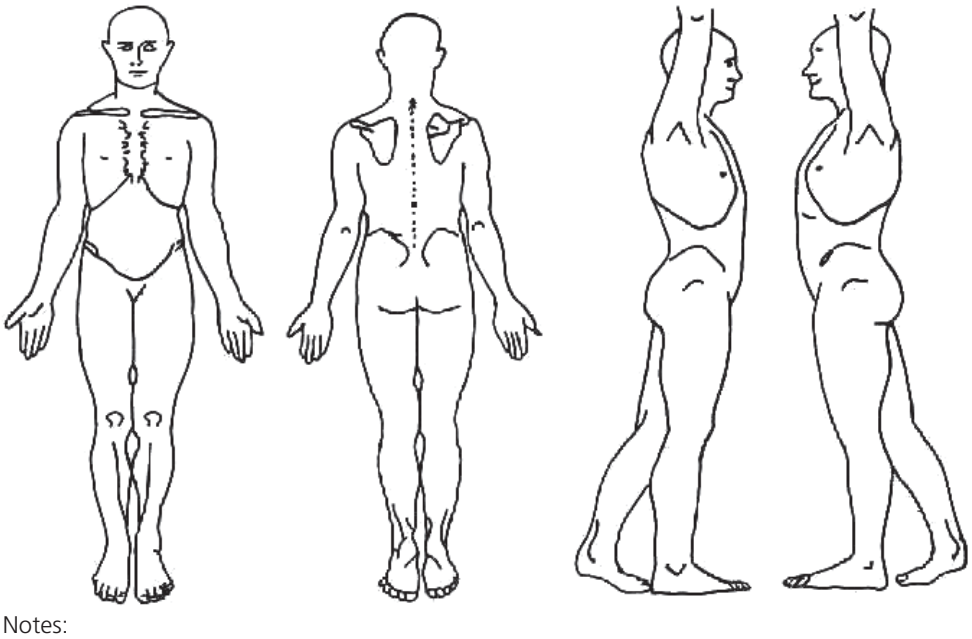


Notes:

Diagnosis:

Treatment:

Date



Notes:

Diagnosis:

Treatment: