Patient Name:____

Address:____

Work phone: _______________Home: ___________________ Mobile: ________________

DOB:_______________ Occupation:____

Email: ____
(*We are sending regular newsletters informing you of upcoming specials - you can opt out any time)

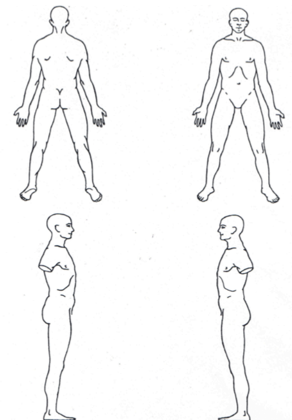
Next of kin/emergency contact:____

Private Health Fund Medicare No.______________________________ ref.____

DVA Workcover Claim No.____________________ others ________________

Referring Doctor:____

Area of pain:____



On the line provided, please mark where your 'pain status' is today.

No pain ________________________________ Most severe pain

Where did you hear about Shockwave Therapy Centre:

GP/specialist ________________ Yellow pages Facebook internet search/BT webpage

Friend/Family, name:____________________ living local/sign other______________

MISSED APPOINTMENT POLICY- PLEASE READ AND INITIAL

Please note that 24 hours notice must be given if you have to change or cancel your appointment. Failure to do so or if you fail to attend an appointment without any notice, the full treatment fee will be charged. Please note, cancellation fees are not covered by a third party and must be paid by the patient.

Please initial ____________

I hereby authorise and grant permission to the treating Physiotherapist to carry out any assessment and examination, procedures, and treatments as may be necessary to assess and treat my condition or injury.

Date __________________________ Signature ____________________________