

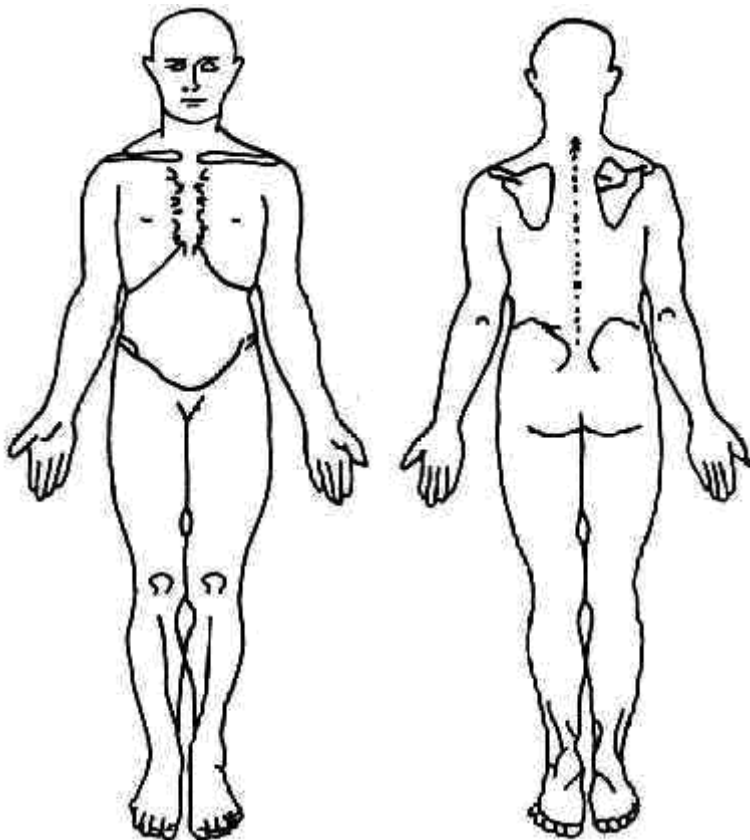
**Physiotherapy Self Referral Form.**

**Please fill out ALL 3 pages of this form and ensure you use BLOCK CAPITALS.**

**The self referral service is not available to under 16's or for neurological, respiratory, obstetric and gynecological problems.**

Full Name	
Address	
Post Code	
Date of Birth	Your Contact Telephone Numbers
GP Name	Home Tel
Practice	Work Tel
	Mobile

Indicate on the pictures where you get your symptoms. For example pain, pins and needles, numbness.



Please return this form to: **Physiotherapy Department, Glangwili General Hospital, Dolgwili Road, Carmarthen, SA31 2AF.** Tel:01267227470 or **Physiotherapy Department, Prince Phillip Hospital,Dafen Road, Llanelli SA14 8QF .Tel: 01554 783204.**

Please give a brief description of your symptoms, or why you wish to see a physiotherapist.
How long have you had the problem? Days      Weeks      Months      Years
How did it start? (Eg: Just came on, injury, fall, long term problem etc)
Are you in pain all the time or does it come and go? Pain all the time <input type="checkbox"/> Comes and goes <input type="checkbox"/> How often do you have the pain? .....
What makes the pain WORSE?
What makes the pain BETTER?
Is it generally worse? Tick answer that applies most In the morning <input type="checkbox"/> in the afternoon <input type="checkbox"/> in the evening <input type="checkbox"/> at night <input type="checkbox"/> no pattern <input type="checkbox"/>
Are you off work or unable to care for a dependent because of this problem? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please give details)
Please indicate any activities you are unable to do because of this problem.
If this is a problem with your joints: Does the joint: Give way Yes <input type="checkbox"/> No <input type="checkbox"/> , Click Yes <input type="checkbox"/> No <input type="checkbox"/> , Lock Yes <input type="checkbox"/> No <input type="checkbox"/> , Swell Yes <input type="checkbox"/> No <input type="checkbox"/>
Please list <b>All</b> of the medication you are taking.
What are your expectations from physiotherapy?

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Have you been to Physiotherapy for this before? Yes <input type="checkbox"/> No <input type="checkbox"/>

<p>Since the onset of this problem, do any of the following apply to you? If you have the symptoms please tick 'Yes' If you do not have the symptoms please tick 'No'</p>		
	Yes	No
Severe pain at night that wakes you.	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Problems swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Does sneezing change your symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with speaking	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with walking	<input type="checkbox"/>	<input type="checkbox"/>
Pins and needles anywhere	<input type="checkbox"/>	<input type="checkbox"/>
Numbness anywhere	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

<p>Since the onset of this problem do any of the following statements apply</p>		
Bladder problems – Difficulty in passing water or a feeling that you can not empty your bladder.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bowel problems – a loss of bowel control (soiling yourself)	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>

General Health	Yes	No		Yes	No		Yes	No
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	History of cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Lung / Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fractures / Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

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If you have answered YES to any of the above or have any other medical problems, please provide further details here:

Did your GP suggest you contact the service: Yes  No

Patient signature:

Date: