



Espoon Keskuksen Fysioterapia

Information Form for Physiotherapy and Podiatry

Name _____

Social security number (Finland) _____

Address _____

Postal code _____ Phone _____

Town/city _____ Email _____

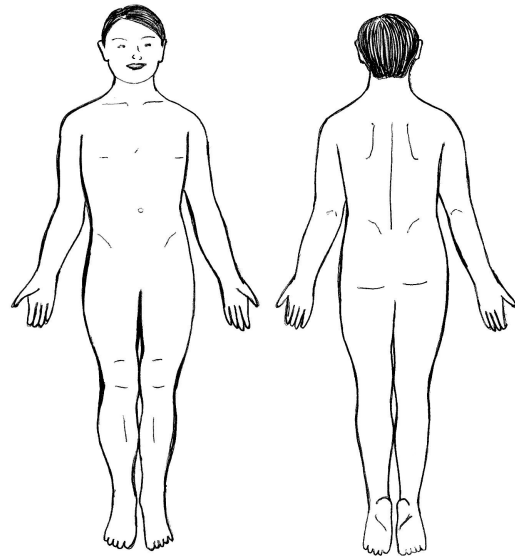
Profession _____

Payer self other, who? _____

How did you find us? on the internet on Facebook via Entresse's advertisements
 heard from an acquaintance I knew the company already via OmaFysio

Please use the signs below and draw them on the body to the parts where you are experiencing symptoms:

- Ache, dull pain **XXX**
- Stitch, sharp pain **•••**
- Numbness **///**
- Radiating pain **—▶**
- Tiredness or stiffness **OOO**
- Swelling or edema **TTT**



Mark the intensity of the pain in the last 24 hours on the line below:

No pain _____ Worst possible pain

How long have you had symptoms? _____

Are the symptoms restraining everyday life? How?

Are you on a sick leave? No Yes, time period: _____

Has the area of the symptoms been imaged (X-ray, MRI etc)? _____

Are you pregnant? No Yes, week: _____

Do you smoke? No Yes

Do you have any of the following:

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> heart pacemaker | <input type="checkbox"/> cardiovascular disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> metal in your body | <input type="checkbox"/> rheumatism | <input type="checkbox"/> tumor | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> contagious disease | <input type="checkbox"/> other, what? _____ | |

Medication _____

Do you have allergies, as nickel? No Yes, for _____

How do you exercise and how often?

Have you received treatment for the same problem?

The given information will be saved to our patient register. The information will be handled only concerning the treatment. The information is under confidentiality and it will be handed over only based on the law or your permission. You have the right to check the information saved to the register.

Approval for handing over the patient information to:

- a doctor or institute taking care of you
- the payer of the treatment
- relative: _____
- other: _____
- I do not want my information to be handed over

A fee of **30 €** will be charged from the patient for an absence or cancellation, that hasn't been made the day before at the latest.

Espoo ___/___ 20___

Signature and clarification of the name