**Meeting The Criteria For A Face-To-Face Appointment**

**Belper Life-Fitness Physio**

Although the CSP have given us more guidance from 1st June this does not mean we can return to ‘business as usual’. We are given scope to assess whether a client meets the criteria for a face-to-face appointment. The list of questions below will help us make this decision. Largely this decision is led by our governing body and I cannot go against their recommendations. Please answer the questions below and return this form to us.

Name:…………………………………………..Telephone number………………………..

DoB:…………………………………………………………………………………………….

1. What is the nature of your symptoms for which you are seeking Physiotherapy Treatment? E.g. Location, If the pain refers, cause if known:
2. How long have you had these symptoms for?
3. Have you received any medical/physiotherapy advice for this condition? If YES please state what you received and when.
4. Please rate your pain on a scale of 0-10, 0 being no pain and 10 being the worst pain imaginable:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 5. | Has any previous medical or physiotherapy input received helped your current symptoms? |  |  |
| 6. | Have you tried exercises and self-treatment methods for your current symptoms? |  |  |
| 7. | Are you using regular pain relief for your symptoms and if so, does it help? |  |  |
| 8. | Is your sleep affected by your current symptoms?If YES describe your sleep pattern: |  |  |
| 9. | Are you off work due to your current symptoms?If YES for how long: |  |  |
| 10. | If you work or are carer for dependants/family, is this moderately or severely affected by your current symptoms? |  |  |
| 11. | Are you experiencing any of the following: | YES | NO |
|  | 1. Numbness, tingling, or muscle weakness
 |  |  |
|  | 1. Unexplained weight loss or night sweats
 |  |  |
|  | 1. Dizziness, Falls, Loss of mobility
 |  |  |
|  | 1. Difficulty swallowing or speaking
 |  |  |
|  | 1. Changes in bladder or bowel
 |  |  |
|  | 1. Do you have a history of cancer or other serious illness
 |  |  |
| 12. | Please state any further information you feel is relevant below: |  |  |

Print Name……………………………………………………………………………………

Signed…………………………………………………………………………………………

Date Submitted………………………………………………………………………………

Please email back to info@belperlifefitnessphysio.co.uk

Clinic Use Only:

Date Received………………………………………………………………………………

Assessment Completed by………………………………………………………………..

Clinical Decision……………………………………….Date………………………..........

Further information below e.g. telephone consultation, referral, recommendations: