



Patient record: Physiotherapy

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Referral and Complaint

Referred by

Presenting complaint

Symptom onset date

____ / ____ / ____
dd/mm/yyyy

Mechanism of injury

☐ Acute trauma ☐ Chronic overuse ☐ Post-surgical ☐ Degenerative ☐ Unknown

2. Pain Assessment

Pain score

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain character

☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Shooting

Aggravating and easing factors

3. Medical History

Previous surgery? ☐ Yes ☐ No

If yes, give details:

Cardiovascular conditions? ☐ Yes ☐ No

If yes, give details:

Osteoporosis or previous fractures? ☐ Yes ☐ No

If yes, give details:

Pregnant? ☐ Yes ☐ No

If yes, give details:

Current medications

4. Objective Examination

Body map

Space for a photo or sketch

Observation and posture

Range of motion and strength

Joint	Movement	Active	Passive	Strength

Special tests

5. Treatment Plan

Physiotherapy diagnosis

Treatment goals

Planned sessions

Home exercise programme

6. Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.

2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.

3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.

4. I authorize the physiotherapist and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.

5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

7. Session Log

Sessions

Date	Session #	Treatment given	VAS after	Notes

Signature

Date

____ / ____ / ____
dd/mm/yyyy