CONFIDENTIAL PRACTICE INTAKE FORM FOR THE OFFICE OF PROFESSOR CATHAL MORAN

PERSONAL DETAILS		
NAME		
ADDRESS		
E-MAIL ADDRESS		
DOB DD/MM/YYYY		CONTACT NUMBER

NEXT OF KIN DETAILS
NEXT OF KIN NAME
NEXT OF KIN CONTACT NUMBER
RELATIONSHIP TO PATIENT (PARENT/SPOUSE/ETC.)

MEDICAL INSURANCE DETAILS		
DO YOU HAVE PRIVATE MEDICAL INSURANCE?	YES ☐	NO ☐
IF YES PLEASE PROVIDE NAME, PLAN & POLICY NO. BELOW		
NAME OF INSURANCE PROVIDER		
NAME OF PLAN		
POLICY NUMBER		
DATE POLICY FIRST COMMENCED	DD/MM/YYYY	
HAVE YOU COMPLETED YOUR WAITING PERIOD	YES ☐	NO ☐
DURATION OF POLICY	APPROX. NUMBER OF YEARS	
HAVE YOU HAD CONTINUED COVER WITH ANOTHER INSURANCE PROVIDER	YES ☐	NO ☐
IF YES PLEASE PROVIDE NAME OF PREVIOUS PROVIDER & DATE THAT POLICY ENDED		

CLUB INSURANCE DETAILS (FOR ATHLETES WHOSE COSTS ARE BEING COVERED BY THEIR CLUB)	
NAME OF CLUB	
NAME OF CLUB SECRETARY OR TREASURER	
CONTACT EMAIL ADDRESS	
CONTACT NUMBER	

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MEDICAL HISTORY DETAILS			
NAME			
OCCUPATION		AGE	
TODAY'S CONSULTATION RELATES TO RIGHT KNEE ☐	LEFT KNEE ☐	RIGHT SHOULDER ☐	LEFT SHOULDER ☐
WHEN DID THIS PROBLEM START?	DD/MM/YYYY		
IS THE PROBLEM A RESULT OF	A SPORTS INJURY ☐	A WORKPLACE INJURY ☐	AN ACCIDENT ☐
IS THERE A MEDICO-LEGAL CASE ONGOING OR PLANNED?	YES ☐	NO ☐	

WHAT HAVE YOU DONE FOR THIS PROBLEM TO DATE?	
MEDICINE	
PHYSICAL THERAPY	
INJECTIONS / SURGERY	

MEDICAL/SURGICAL HISTORY					
PAST / CURRENT MEDICAL CONDITIONS					
PREVIOUS SURGERY					
ARE YOU A DIABETIC?	YES ☐	NO ☐	INSULIN ☐	NON-INSULIN ☐	
ALLERGIES?	YES ☐ IF YES PLEASE LIST BELOW		NO ☐		
LIST OF ALLERGIES					
LIST CURRENT MEDICATIONS					
DO YOU TAKE ANY OF THE FOLLOWING?	WARAFIN ☐	PLAVIX ☐	ASPIRIN ☐	HRT ☐	CONTRACEPTIVE PILL ☐

GP & PHYSIOTHERAPIST DETAILS	
GP NAME & FULL ADDRESS	
PHYSIO NAME & FULL ADDRESS	
REFERRING DOCTOR/PHYSIO NAME & FULL ADDRESS	