



## **Symptom History**

*Please tick as appropriate:*

When did this problem start?

Less than 2 weeks     2-6 weeks     4-6 weeks   
6-12 weeks     More than 12 weeks

Is the problem:

new?     ongoing?     getting better?   
getting worse?     staying the same?

Does it wake you at night?

Yes     No

Is the problem stopping you from working?

Yes     No

Is there anything the problem is stopping you doing?

Yes     No

Please Specify:

## **Pain**

If you have pain please indicate how severe your pain is on this line on a scale of 0—10.:



0   1   2   3   4   5   6   7   8   9   10



No pain at all

Worst pain

**Medical History:** Provide a brief summary of your medical history:

*Please tick as appropriate*

Have you consulted your GP about this problem?

Yes     No

Have you tried anything to help with your problem? (e.g. pain killers, exercise, other treatment)

Yes     No

Please specify:

Have you had Physiotherapy for the same problem in the last 6 months?

Yes     No

Where did you have your physiotherapy?

Please take, send or fax your completed referral form to:

**Physiotherapy Department, Colwyn Bay Hospital, Bryn Avenue, Colwyn Bay. LL29 8AY. Fax: 01492 807580**

Please state where you would like to be seen:

A Physiotherapist will look at your form. We will then read the referral and triage the referral as urgent or routine. If your referral is triaged as urgent we will aim to contact you as soon as possible to make an appointment. If it is triaged as routine, you will receive a letter to contact us to make an appointment when you get to the top of the waiting list.