**Supplementary file 1:** Survey questionnaire completed by the Sport and Exercise Physicians.

| **Section 1 - Patient's referrer and main condition** | |
|---|---|
| Date you saw the patient | ______________________________ |
| Who referred the patient? | ○ GP<br>○ Specialist<br>○ No referral<br>○ Other |
| Please specify | ______________________________ |
| How long was the consultation with the patient? | ○ < 15 minutes<br>○ 15-30 minutes<br>○ 30-45 minutes<br>○ 45-60 minutes<br>○ >60 minutes |
| Please identify the main condition the patient presented with: | ○ Musculoskeletal<br>○ Other |
| Please specify: | ______________________________ |
| Please select | ○ Hip/groin/hamstring<br>○ Knee<br>○ Calf/foot/ankle<br>○ Shoulder<br>○ Elbow/wrist/hand<br>○ Head/neck<br>○ Thoracic/lumbar spine<br>○ Other |
| Please specify | ______________________________ |
| How long has the patient had symptoms? | ○ < 3 months<br>○ 3-6 months<br>○ 6-12 months<br>○ >12 months |
| Does the patient have any other conditions that you have/will be treating them for? If yes, please list them. | ______________________________ |

All remaining questions relate the to the patient's main condition that you saw them for.

| **Previous consults and diagnoses for this condition** | |
|---|---|
| Has the patient previously seen any of the following allied health professionals for this condition? (Select all that apply) | ☐ Physiotherapist<br>☐ Osteopath<br>☐ Acupuncturist<br>☐ Podiatrist<br>☐ Exercise physiologist<br>☐ Chiropractor<br>☐ None of the above<br>☐ not sure |
| Approximately how many times in total for these allied health consultations? | ________________________________ |
| Has the patient previously seen any other medical practitioners for this condition? (Select all that apply) | ☐ GP<br>☐ Orthopedic surgeon<br>☐ Other surgeon<br>☐ Endocrinologist<br>☐ Rheumatologist<br>☐ Neurologist<br>☐ Other SEM physician<br>☐ Other<br>☐ Hasn't seen anyone else<br>☐ Not sure |
| Approximately how many times in total for other medical consultations? | ________________________________ |
| Has the patient had any previous diagnoses by others for this condition? | ○ Yes<br>○ No |
| What was the diagnosis? | ________________________________ |
| Has this diagnosis changed following the consult with you? | ________________________________ |

| **Previous treatments and investigations for the patient's main condition** | |
|---|---|
| Has the patient already been prescribed/directed to take any medications by previous practitioners for this condition?<br>(Select all that apply) | ☐ No medications<br>☐ NSAIDs<br>☐ Steroidal anti-inflammatories<br>☐ Non-opioid analgesia (eg paracetamol)<br>☐ Opioid analgesia<br>☐ Neuromodulating drugs / antidepressants<br>☐ Supplements<br>☐ Other |
| Please specify: | __________________________ |
| Has the patient had any interventions already for this condition?<br>(Select all that apply) | ☐ Injectables<br>☐ Surgery<br>☐ Shockwave<br>☐ Other |
| Please specify which injectables:<br>(Select all that apply) | ☐ Cortisone injection<br>☐ PRP / Autologous blood<br>☐ Prolotherapy<br>☐ Viscosupplements<br>☐ Stem cell<br>☐ Other |
| Please specify | __________________________ |
| Please comment on whether these interventions were helpful for the patient | __________________________ |
| Has the patient had any previous radiological assessments for this condition? (i.e. requested by previous practitioners, not you)<br>(Select all that apply) | ☐ Xray<br>☐ MRI<br>☐ CT<br>☐ Ultrasound<br>☐ DEXA<br>☐ Other<br>☐ No radiological assessments |
| Please specify | __________________________ |
| Please comment on whether these radiological assessments were helpful in determining the diagnosis or management plan | __________________________ |
| Has the patient had any previous lab/pathology assessments for this condition? | ○ Yes<br>○ No |

| **Patient's comorbidities/other issues** | |
|---|---|
| Does the patient have any comorbidities/other issues relevant to the condition they presented with (which will need to be taken into account with their management)? | ☐ Overweight/obesity<br>☐ Work-related concerns (including sport for professional athletes)<br>☐ Psychological issues<br>☐ Smoking cessation<br>☐ Hypertension<br>☐ Sleep issues<br>☐ Travel requirements<br>☐ No comorbidities/other issues<br>☐ Other |
| Please specify | ______________________________ |
| Does the patient take any medication for a comborbidity/other issue that needed to be taken into account for their SEM treatment? | ○ Yes<br>○ No |

**Your SEM management plan for this patient**

Please briefly describe your management plan for this patient in the following sections.

| | |
|---|---|
| Additional outward referrals (to whom, anticipated treatment): | ______________________________ |
| Investigations (eg radiology, pathology) | ______________________________ |
| Treatment: | ______________________________ |
| Estimate of the number of visits to a SEM physician anticipated for this patient (including this visit) | ________________________ |