



Welcome to our clinic



Please take a few minutes to complete this questionnaire so we may evaluate your condition thoroughly. When you have finished, please return it to your receptionist.

Name _____ Date of Birth ____/____/____ Age ____ (yrs)
 Address _____ Suburb _____ Postcode _____
 Occupation _____ (H) _____ (W) _____ (M)
 Email Address (For newsletters & Special offers) _____
 Marital Status _____ Children(ages) _____ Pregnant or Breast feeding? yes no
 Do you have Podiatry private health insurance? (claims can be electronically processed here) yes no
 Who referred you to this clinic ? Ms/Mr/Dr _____ GP/Specialist
 Sign Website/Internet Your coach _____ Sports club/Association
 Have you had previous Podiatric care? yes no Date of your last consultation ____/____/____
 Treatments your Podiatrist Used: Custom Orthotics Shock Wave Therapy Dry needling
Other _____

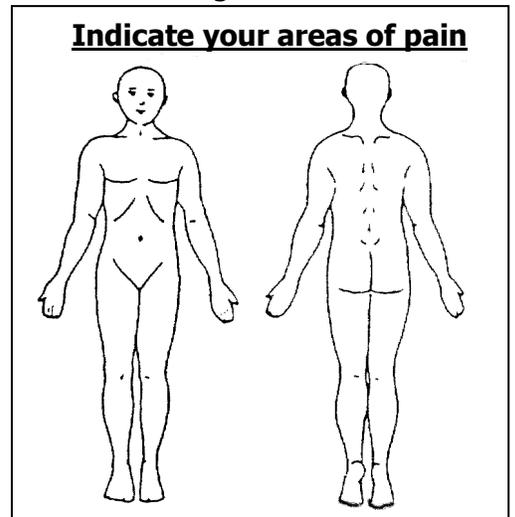
Please describe your present complaint and illustrate the affected areas on the diagram:

Are there any other injuries/problems bothering you ?

Please list any illnesses you have

Please list any drugs, medicines or vitamins you take

Have you had any x-rays taken in the past five years ? If yes, please detail: _____



Please outline all sporting activities/training habits/hobbies and your level of participation

Please tick (✓) the corresponding box if you have suffered from any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease/goiter | <input type="checkbox"/> H.I.V. / A.I.D.S. |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> T.B. | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Multiple sclerosis |

It is customary to pay for all professional services when rendered. This centre does not send accounts. Payment for all services may be made by cash or Eftpos facility. We require a minimum of 24 hours notice for appointment rescheduling or a cancellation/non attendance fee will apply.

Client Signature _____ Date ____/____/____