

Client Registration Form - Podiatry

(1) Title: Mr Mrs Ms Miss Other _____ First Name: _____ Surname: _____

Residential Address: _____ Suburb: _____ State: _____ Postcode: _____

Postal Address: _____ Suburb: _____ State: _____ Postcode: _____

Do you identify as Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Date of Birth: ____/____/____ Sex: Male Female

Tel:(home): _____ (work): _____ (mobile): _____

(fax): _____ Email: _____

Note: We require your email for communicating with you about your treatment. WE DO NOT SEND SPAM. Furthermore, we only send reward vouchers and special offers to you. You can unsubscribe at any time.

Area of Injury (eg. left knee, back etc): _____

Occupation / Study: _____ Hours per week: _____

Sport / Recreational Activities: _____ Hobbies (piano / woodwork etc): _____

(3) Were you referred to this clinic by a health professional ? No Yes: Name of Referrer: _____

(4) How did you find out about us? Our Website Brochure / Flyer Google / Internet Search

Facebook Other: _____ Friend / Family — Name: _____

Workshop: _____ From my Sports Club/Gym/Trainer : _____

(5) Have you ever seen another therapist for any previous or current injuries? No Yes

If yes, what aspects were you most happy about? _____

Is there anything that you were not happy about? _____

(6) Name of local Doctor: _____ Clinic/Suburb: _____

(7) In what ways is your current injury affecting your capacity to live life as you would like to? _____

(8) What are the two main things you would like to achieve from your initial treatment TODAY?

(a) _____ (b) _____

(9) Is there any reason that it is important to you to fix this problem as soon as possible? _____

Conditions of Treatment

I understand that should I cancel or not attend a scheduled Physiotherapy, Podiatry or 30 min Remedial Massage appointment without providing 24 hrs notice, that a fee of \$30 will be charged and a fee of \$50 will be charged for a 60 min Remedial Massage. Not attending an appointment is an inconvenience to the clinic, our other patients (we have a long waiting list), and generally means you require more treatment to recover. **For insurance claims:** I hereby acknowledge and understand that should my claim be rejected in any way that I will be responsible for payment of accounts for any and all services received.

I consent Sport & Spinal Physiotherapy and Your Podiatry Canberra contacting relevant third parties in relation to my ongoing care and treatment such as my GP. I understand this is necessary to assist with my ongoing treatment. Please read our term and conditions as stated on our website at www.yourpodiatrycanberra.com.au/terms-and-conditions

Patient's signature _____

Date _____

New Client Agreement

Thank you for choosing Sport & Spinal Physiotherapy and Your Podiatry Canberra as your health provider. We truly appreciate your support and will do our absolute best to provide you with exceptional health care solutions for many years to come.

We Need Your Help

To ensure we provide you and our other valued clients with the best possible care, it is important that you understand and agree to our terms and conditions as outlined below:

1. **Be on Time:** All clients are expected to **arrive on time for each and every appointment**. We will do our absolute best to not keep you waiting also.
2. **24 Hours Notice of Cancellations:** As we are a busy and professional health provider, all clients must accept and agree to our cancellation policy. Failure to attend scheduled appointment not only disrupts your treatment progress but also takes the spot of another client who may have been able to attend in your place. If you are unable to attend a scheduled appointment **you must give us 24 hours notice**, otherwise a cancellation fee will be charged.
3. **We Appreciate Your Feedback** – at the end of your session **today you will be emailed a short feedback form** where you get the chance to let us know how our admin team and therapists managed your care. Your input is highly valued so that we can continue to improve our service.
4. **Pay at the Time of Consult** – consultation fees for all private clients are to be **paid at the time of consultation. No invoices will be given.** Workers Compensation and CTP client's invoices are sent directly to their insurer provided all necessary claim numbers and paperwork are submitted. Should the claim be rejected for any reason, all invoices become the responsibility of the client.
5. **Your Treatment Plan** – To ensure the greatest success for your treatment, we suggest booking your appointments two weeks in advance. This will also ensure that you secure appointment times that suit you.
6. **Referrals Welcomed** - We thank you in advance for any referrals to our business. If you do refer your friends and family to our practice, you will be rewarded with a **free 30 minute massage** for each referral..

Clients Name: _____ : Date _____

Client Signature: _____ Admin Name: _____

Podiatry Questionnaire

Check and comment on any medical conditions:

- Cardiac (heart) and vascular: _____
- High blood pressure: _____
- High cholesterol: _____
- Respiratory /breathlessness/asthma: _____
- Arthritis: _____
- Osteoporosis: _____
- Digestive /abdominal: _____
- Cancer: _____
- Diabetes: _____
- Epilepsy: _____
- Depression / anxiety: _____
- Infectious diseases: _____
(e.g. hepatitis or in last 12 months gastroenteritis, conjunctivitis, STIs)
- Allergies: _____
- Other: _____

(1) List medications and what they are for (including supplements, vitamins): _____

(2) Previous or upcoming surgeries: _____

(3) Previous injuries: _____

(4) Please circle the type of shoes that you wear:

Athletic/joggers/runners lace ups mary janes heels workboots ballet flats thongs

(5) Do you currently wear or have previously worn orthotics? _____

(6) Please circle area of concern/s

Knee Shin Calf Achilles Ankle Skin e.g. calluses, corns
Heel Arch Ball of foot Bunion Toenails Other: _____

(7) Is there a family history of any medical conditions? _____

(8) If you are suffering from lower limb pain rate/circle your pain at its worst. 0 being no pain at all and 10 being the worst pain imaginable:

0 1 2 3 4 5 6 7 8 9 10