"Keeping you on your feet"

The Foot & Ankle Clinic®
Podiatry and Footwear

WELCOME TO OUR PODIATRY CLINIC

"We are a family centred Podiatry Clinic dedicated to the detection, correction and prevention of foot and lower limb problems. We are committed to educating our patients and the community about the role of Podiatry in Healthcare."

We aim to provide optimal prevention and long term foot and lower leg care in a professional environment that is friendly and informative.

To assist our treatment of you please complete the following

(Feel free to ask for assistance where necessary and parents please complete on behalf of your children)

Patient's Name: Mr/Mrs/Ms/Miss/Mstr ..... (Given) ..... (Surname)

Address: ..... **Postcode:** .....

Date of Birth: ..../..../.... **Occupation:** .....

Phone: Home ( ) ..... Work ( ) ..... Mobile .....

Email: .....

Emergency Contact Name: Mr/Mrs/Ms/Miss ..... (Given) ..... (Surname) **Relationship:** .....

Emergency Contact Phone No. .....

If there was anybody who recommended or referred you to us please indicate whom so we can thank them?

Name: Mr/Mrs/Miss/Dr: .....

❏ Doctor ❏ Chiropractor ❏ Diabetic Advisor ❏ Friend
❏ Nurse ❏ Family Member ❏ Physiotherapist ❏ Masseur
❏ Other .....

If you were not referred by anyone in particular, how did you find out about us?

❏ Yellow Pages ❏ Newspaper ❏ Television Advertisement ❏ Radio
❏ Street Signage ❏ Public Talk ❏ Word-of-mouth ❏ Foot Screening
❏ Facebook/Social Media ❏ Google Search ❏ Internet ❏ Other .....

Do you have Private Health Insurance with Podiatry cover? ❏ Yes ❏ No If yes, which health fund are you a member of? .....

Do you have a Pension Card? ❏ Yes ❏ No Please indicate your card number: .....

Have you ever visited another Podiatrist? ❏ Yes ❏ No If yes, who/where/when did you see them last? .....

Has another immediate family member attended our clinic? ❏ Yes ❏ No

Who is your General Practitioner or Family Doctor? Dr: ..... Medical Clinic: .....

To enable to keep our fees below the recommended fee schedule we do not issue accounts. Please indicate how you intend paying for today's service once you have seen the Podiatrist.

❏ Cash ❏ Cheque ❏ Credit Card ❏ Eftpos (Selected Clinics Only)

❏ Veterans' Affairs ❏ VX No. .....

❏ Medicare Plus ❏ Medicare No. .....

NDIS/TAC/Workcover Patients Only:

Accident/Plan Date: ..../..../.... Claim/NDIS No: .....

If NDIS, how are you managed? ❏ Self Managed ❏ NDIA Managed ❏ Plan Managed

Insurance/Plan Managed Company: .....

Address: .....

Phone: ..... Email: .....

Claims Officer/Plan Manager: ..... Referring Doctor: .....

Nature of Injury: .....

MEDICAL HISTORY - Please assist our assessment, evaluation and treatment of your problem by answering the following questions:

What type of footwear do you wear most often?

❑ BARE FEET ❑ SANDALS ❑ SLIPPERS ❑ ATHLETIC SHOE ❑ OTHER
❑ COURT/DRESS SHOE ❑ LACE-UP SHOE ❑ SCHOOL SHOE ❑ WALKING SHOE

What type of sport do you play regularly? ..... ❑ None

List any major Falls, Accidents, Fractures you have had in your lifetime: .....

.....

Have you ever had any form of foot or ankle surgery? ❑ YES ❑ NO If **YES**, please indicate what type: .....

.....

List any other relevant surgery you have had and approximate dates: .....

.....

List any long-term or chronic medical conditions you suffer with any medication you are currently taking and dosages ❑ None

.....

.....

Are there any illnesses that run in your family? ❑ Yes ❑ No Comment: .....

Previous X-Rays: ❑ Yes ❑ No Comment/Where?: .....

Do you or have you ever suffered any of the following:

Allergies: ❑ Yes ❑ No Comment: .....

Diabetes: ❑ Yes ❑ No If **YES**, are you: ❑ Insulin Controlled (Type 1) ❑ Non Insulin (Type 2) Year Diagnosed (approx): .....

Skin Conditions (including ulcerations): ❑ Yes ❑ No Type/Where?: .....

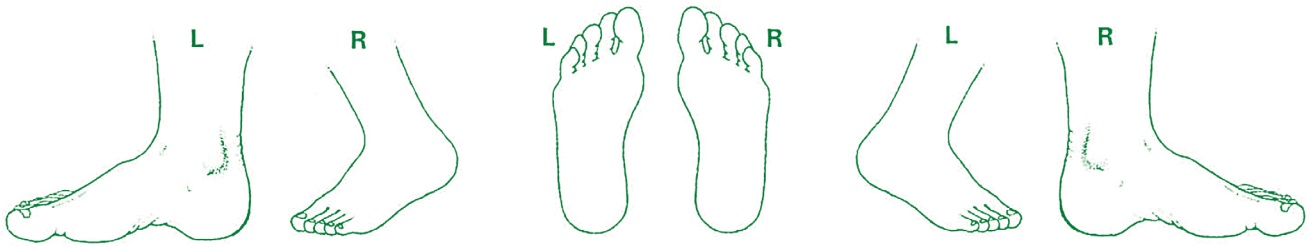
.....

Arthritis: ❑ Yes ❑ No Where?: .....

My reasons for visiting this clinic are: .....

.....

PLEASE MARK WHERE YOUR PAIN IS ON THE DIAGRAM BELOW



Please tick the box that best describes the nature of your pain

❑ Constant ❑ Intermittent ❑ Dull ❑ Sharp **PLEASE INDICATE THE LEVEL OF PAIN (1=LOW, 10=HIGH) PAIN** ..... **/ 10**

How long have you had this problem?: ..... **YEARS** ..... **MONTHS**

Do you suffer chronic or regular pain in any other part or areas of your body? .....

.....

PRIVACY STATEMENT

So we can provide you with optimal service and treatment we need to obtain personal information about yourself and at times disclose these details or obtain further information regarding your care from related third parties. Such organizations can include, but are not limited to: other medical and allied health practitioners, Medicare, the Department of Veterans' Affairs, NDIS, TAC, Workcover, Diagnostic and Pathology Services and any other third party that may make payment for our services on your behalf.

We advise that in all cases information disclosed and obtained is strictly relevant to the condition for which you require treatment.

If you do not wish for us to divulge any information relating to your presenting problem to any other practitioner or interested third party please notify your Podiatrist or one of our Podiatry Assistants.

Should you wish to access any personal information we hold on your behalf or obtain more information about The Foot and Ankle Clinic, please contact your attending Podiatrist or the Team Leader at the clinic you attend.

Thank you,
THE FOOT AND ANKLE CLINIC PTY. LTD.

I confirm that I have read the above Privacy Statement and that the details and information I have provided on this form are accurate and completed to the best of my knowledge.

Signature: ..... **Date:** ..... / ..... / .....