**Stride Podiatry**

*Office Use Only:*

ENTERED:🞎

SCANNED:🞎

**Client Consent and Information Form**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 1 - PERSONAL INFORMATION** | | | | | | | | | | |
| TITLE: | |  | | | | **PHONE:** | | |  | |
| **FIRST NAME:** | |  | | | | **WORK PHONE:** | | |  | |
| **PREFERRED NAME:** | |  | | | | **MOBILE:** | | |  | |
| **LAST NAME:** | |  | | | | **EMAIL:** | | |  | |
| **GENDER:** | |  | | | | **HOME ADDRESS STREET:** | | |  | |
| **DATE OF BIRTH:** | |  | | | |
| **NAME OF GP:** | |  | | | | **POST CODE:** | | |  | |
| **MEDICAL PRACTICE:** | |  | | | | **ETHNICITY:** | | |  | |
| **OCCUPATION:** | |  | | | | **EMPLOYER ADDRESS:** | | | | |
| **EMPLOYER NAME:** | |  | | | |
| **WHY DID YOU CHOOSE US :**  🞎 Recommended Clinic | | | 🞎 Recommended  Who: \_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Been Before  🞎 Doctors Referral | | | | | 🞎Location  🞎 Other: |
| **WHO REFERRED YOU?** 🞎 GP | | | 🞎 Specialist 🞎 Physiotherapist | | | | 🞎 Friend/Family 🞎Other: | | | |
| **Would you like to be reminded of your appointment via text messaging:** 🞎 Yes 🞎 No  **Would you like to receive any e-mail information about our services:** 🞎 Yes🞎 No | | | | | | | | | | |
| **SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:** | | | | | | | | | | |
| 🞎 Pregnant  🞎 Physical disability  🞎 Diabetes | 🞎 Heart problems  🞎 Skin condition  🞎 Cancer  🞎 Pacemaker | | | 🞎 Hearing/Sight impaired  🞎 Hep C/HIV  🞎 Other (Specify) \_\_\_\_\_\_\_\_\_\_\_  🞎 Circulation/Vascular Problem | | | | 🞎 Asthma/Respiratory/Breathing  🞎 Artificial Implants  🞎 Allergy (Specify)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **HAVE YOU USED OR ARE USING STEROIDS** 🞎 **ANTICOAGULANTS** 🞎  **OTHER MEDICATIONS:** | | | | | | | | | | |
| **SECTION 3 – CONSENTS** | | | | | | | | | | |
| I hereby agree to consent to treatment by an appropriately qualified Podiatrist for the purpose of providing comprehensive podiatry services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion. | | | | | | | | | | |
| **AGREEMENT TO PAY:** | | | | | | | | | | |
| I understand that I am liable to pay for :   * Any private treatment or co-payment charges for ACC treatments * Any treatment that is declined by ACC or other funder * The costs of materials such as orthotics, materials, products etc | | | | | | | | | | |
| **CONSENT TO RELEASE INFORMATION TO A 3rd PARTY** | | | | | | | | | | |
| I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.  I consent to a discharge/update report being sent to my doctor or medical centre. | | | | | | | | | | |
| I have read and understand the information above.  **SIGNED: DATED:**  *(If under 16 must be signed by parent/guardian)* | | | | | | | | | | |