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PODIATRY HISTORY AND INFORMED CONSENT

ABOUT YOU

Name: _____ Date: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

Postcode: _____

Phone (H): _____ Mobile: _____ (W): _____

Email: _____

Sex: Male Female

Relationship Status: Single Married Divorced Widowed Children (# of): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Occupation: _____ Type of Work: _____

Name/location of current GP: _____

Allergies: _____

Medications/Medical History: _____

Reason for your visit today: _____

Health Fund: _____

Who may we thank for referring you?: _____

Consent for care

I acknowledge that podiatry is not a substitute for medical care, medical examination or diagnosis.

I have stated all my known medical conditions and I will inform my practitioner of any change in my health status. It is my choice to receive podiatry, I am aware of the benefits and risks, and I give my consent for podiatry. I understand that there is no implied or stated guarantee of success or effectiveness for podiatry sessions. I understand that the client therapist relationship will be held in strict confidence.

Signature.....Date.....