Patient Details

Dated:

Personal Details:

Title: Please select

First Name:

Surname:

Address:

Suburb:

Post Code:

Best Contact:

Email Address:

Can we email you? Please select

Date of Birth:

Occupation:

Parent Guardian (if under 16):

Address (if different from above):

Emergency Contact:

Phone:

Medicare #

Private Health:

Concession:

Is your Account paid by a third party? Please select

If 'Yes', please provide details below:

Entity Name:

Contact Name:

Client Number:

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Present Medical Details:

Your Doctor: When was your last visit?

Address:

Are you happy for us to keep your doctor informed? Please select

Have you seen a Podiatrist before? Please select When?

Your Profile:

Your assessment includes a computerised plantar pressure assessment which requires the following information to calibrate the equipment.

Weight kgs Height cms Shoe Size Euro

Referral:

We appreciate people who feel that our care is worth sharing with their friends and family. This is how our practice continues to grow and we like thanking the people who refer to us.

How did you hear about us?

☐ Health Professional Name: Medical Centre:

☐ Online ☐ Friend / Family Name:

☐ Other Please Specify:

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Medical Details (Please specify if applicable):

Diabetic:	Please select	Other: (e.g. Foot Ulceration)	
Neurological disorder:	Please select	Other:	
Arthritis:	Please select	Other:	
Rehabilitation:	Please select	Other:	
Heart disorder:	Please select	Other:	

Are there any major Foot or Medical problems in your family? Please select

Your Current Concern:

It is important for us to fully understand all the details of your condition. Please take time to note fully and accurately the details of the area/s of your pain.

Previous injuries, accidents or surgery *(To feet, legs and or back. Please list in date order)*

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Your Main Concern:

Describe your main concern:

How long have you had this problem? Is it getting? Please select

What activities / sports do you do at present?

How did it start?

Describe your pain out of 10 (1 = not a lot, 10 = severe): Please select

Is the pain? ☐ Sharp ☐ Aching ☐ Pins & Needles ☐ Dull ☐ Numbness ☐ Discomfort

When is the problem worse?
☐ Morning ☐ Evening ☐ Night ☐ During/After Sport ☐ All Day ☐ Day & Night

What makes things worse?

What makes things better?

Has it occurred before? Please select

What made it better then?

What do **you believe** is causing your pain?

Do **you think** you will get better?

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Rate how much the pain is preventing / reducing your ability to perform your preferred activities out of 10.

Please select

Rate this problem; How important is this to be addressed out of 10? Please select

What goal would you love to achieve and feel confident to work towards?

And, how urgent? Please select

What would you like to be able to do which you are currently not able to do because of the pain / condition?
(e.g. walk, run, go on holidays, wear certain shoes)

Please note any practitioners you have already seen about this problem and what tests/ treatment has been done:

Other Areas of Pain such as Hips, Back or Neck

Many people have other areas of pain over their body such as neck, lower back or hip pain, chronic headaches, etc. We are interested in these other areas as we treat you holistically, knowing that recent medical research indicates that normal functions, such as walking, involves the whole body from head to the toes!

Describe your other concerns/pain:

How long have you had this problem? Is it getting? Please select

How did it start? Is the pain? Please select

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When is the problem worse?

☐ Morning ☐ Evening ☐ Night ☐ During/After Sport ☐ All Day ☐ Day & Night

What makes things worse?

What makes things better?

Please note any practitioners you have already seen about this problem and what tests/ treatment has been done:

Other Information:

If there is any further information you want to give us, please write below:

We look forward to helping you achieve what you can, working with you step by step towards your desired outcome.

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