

## Client Registration Form

(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 (such as Refer a Friend FREE massages) by email.**

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 Webpage \_\_\_\_\_  Social Media  Other: \_\_\_\_\_

From my Friend / Family — Name: \_\_\_\_\_  From my Trainer: \_\_\_\_\_

From my Sports Club/Gym: \_\_\_\_\_

(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? \_\_\_\_\_

## DECLARATION

I, \_\_\_\_\_ client's full name (or parent/guardian in case of U/16) understand and agree to the terms and conditions as stated below.

Client (or Parent/Guardian) Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## TERMS & CONDITIONS

**Cancellation policy. We require a minimum of twenty-four (24) hours notice if you wish to cancel your appointment, or fees may apply.**

The client (or parent in case of U/16) at all times understands and agrees to the following terms and conditions:

- (1) Sport & Spinal Physiotherapy has full authority to release or obtain any information/documents to or from any referring medical practitioner, any referring health provider, the relevant insurance company and/or my stated legal advisor regarding my current medical condition that pertains to my treatment.
- (2) Sport & Spinal Physiotherapy / Gungahlin Podiatry will provide treatment to me.
- (3) I will be **at all times** responsible for payment of my account in full.
- (4) I will need to provide payment of my account in full at the time of consultation until the approval for any compensation claim has been confirmed.
- (5) I remain liable to pay any unrecovered amounts on demand by Sport & Spinal Physiotherapy / Gungahlin Podiatry.
- (6) I acknowledge that an account administration fee of 20% of the total outstanding amount will apply for any consultations not paid at the time of consultation.
- (6) If there is a delay in payment of any treatment costs by longer than 60 days, I acknowledge that a late payment fee of \$25 plus GST will apply monthly.

## DEBT COLLECTION POLICY

In the event where this account is not paid within our trading terms the following shall apply:

- (a) Sport & Spinal Physiotherapy / Gungahlin Podiatry shall be entitled to charge a debt recovery fee of 20% of the total outstanding amount.
- (b) In the event where you fail to pay the whole amount due within 7 days of being so requested to do so by Sport & Spinal Physiotherapy in writing, then we shall be at liberty to instruct a Collection Agency and or solicitors to recover the monies outstanding and you shall be liable for any costs, charges, commissions and expenses reasonably and properly payable by us to such Collection Agency and/or solicitors relating to recovery of such sum.
- (c) Any money recoverable by us from you pursuant to the above clauses (a) and (b) shall be added to the amount otherwise due and shall be recoverable as a liquidated debt.

## 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