New Patient Form
Physiotherapy

BLUE MOUNTAINS Podiatry By OnePointHealth

About You

Title: Mr. Mrs. Miss. Ms (please circle)

Name: _____ DoB:: _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____ Contact No: _____

Medicare Card Number: _____ Individual Reference No: _____

Emergency Contact Name and phone: _____

Are you covered on the National Disability Insurance Scheme (NDIS) ◯ Yes ◯ No

GP's Name: _____

GP's Contact Number: _____

GP's Clinic Name: _____

Workers Compensation or CTP Details

Insurer: _____ DOI: _____

Claim Number: _____

Case Manager's Name: _____

Case Managers Contact No: _____

Case Manager's Email: _____

How did you hear about Blue Mountains Podiatry?

◯ Google Search ◯ Sporting Club/Community Event ◯ OnePointHealth Website

◯ Social Media ◯ Patient/Friend ◯ Location/Signage ◯ Your GP

Please continue on the next page

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Health History:

- ◯ Abdominal / Digestive Problems
- ◯ Allergies
- ◯ Arthritis
- ◯ Asthma or Lung Conditions
- ◯ Blood clots
- ◯ Cancer / Tumors
- ◯ Chronic Pain
- ◯ Chronic Fatigue
- ◯ Depression
- ◯ Diabetes
- ◯ Fatigue
- ◯ Other (to be filled by practitioner)
- ◯ Fibromyalgia
- ◯ Headaches or Mirgrines
- ◯ Hearing Problems
- ◯ Heart, circulatory Problems
- ◯ Hernias
- ◯ High / low Blood Problems
- ◯ Infectious Disease
- ◯ Lymph node Removal
- ◯ Motor vehicle accident / trauma
- ◯ Muscle or joint pain
- ◯ Kidney Issues
- ◯ Osteoporosis/Osteopenia
- ◯ Muscle, bone injuries
- ◯ Numbness or tingling
- ◯ Phlebitis
- ◯ Pregnancy
- ◯ Endocrime Disorders
- ◯ Seizures
- ◯ Skin disorders
- ◯ Stroke
- ◯ Varicose veins
- ◯ Vision problems / contact lenses

By signing below you are giving consent for all practitioners at OnePointHealth to access your patient file including all medical, health and treatment notes. If there are any areas of your personal details you do not want made available to other practitioners please notify your treating practitioner.

During the examination, assessment and treatment it may be necessary for your practitioner to make physical contact. Physical contact requires your express consent and you may withdraw consent at any time, at which point all physical contact will cease immediately. Please inform your practitioner if you feel uncomfortable at any time.

I acknowledge that I have carefully read all of the above information appropriate to the practitioner I am seeing, and that I understand and agree to each point that is made, Once you have given consent, you may withdraw it at any time in writing.

I hereby acknowledge that the information given is true, and I consent to treatment at this practice and the costs incurred and authorise any relevant information to be forwarded to other health practitioners involved in the management of the condition/s when required.

Patients Name: _____ Signature: _____ Date _____

Parent/Guardian Name: _____ Signature: _____ Date _____