Client Ref	

STEPTOES FOOTCARE CENTRE

PATIENT DETAILS

PLEASE PRINT CLEARLY

Title (Mr/Mrs/Miss/Dr etc)	
First Names	
Surname	
Address	
Postcode	
Date of Birth	
Home Telephone Number	
Work Number	
Mobile Number	
E-mail address	
Next of kin	
Relationship	
Telephone Number	
Doctor and Practice	

CONSENT TO CARE AND TREATMENT

I understand the Podiatrist will advise and treat me according to my requirements at each visit.
I understand the podiatrist may use sharp instruments and/or chemicals as part of the treatment of my feet.
If I have any queries regarding the treatment I will clearly ask the Podiatrist at the time.
I consent to ongoing treatment at each visit unless I clearly state otherwise.

I have read the Patient Information Sheet attached.	**YES**		**NO**	

Patient/Parent/Guardian Signature	Date

If you are signing for the patient please give details below

Representatives Name	Relationship to patient

MEDICAL HISTORY

	Yes	**No**	**Details**
Do you have:			
Diabetes			
Problems with your heart			
High or low blood pressure			
Problems with your blood circulation			
A blood disorder			
Problems with your lungs or breathing			
A diagnosed rheumatic condition			
Osteoarthritis			
A neurological condition			
An autoimmune condition			
A thyroid or an endocrine disorder			
Problems with liver or kidney function			
Digestive tract or bowel problems			
A skin disorder			
Allergies			
Problems with your Eye sight			
Hearing problems			
Have you:	**Yes**	**No**	**Details**
Suffered from Epilepsy, Fits or Fainting?			
Had Hepatitis?			
Had a bad reaction to local anaesthetic?			
Further information	**Yes**	**No**	**Details**
Please list any surgical operations			

Are you pregnant?			
Do you need assistance with mobility or use of a wheelchair?			
Have you had any lower limb or foot injuries?			
Are there any other medical/health details about yourself, which we should know?			
Please list any medication you are presently taking and treatment you are undergoing.			