PRIVATE CLINIC CLIENT DETAILS

Blatchford private clinic

Personal Details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify):

First name: Surname: DoB:

Address & Post Code:

Day Time Telephone: Mobile Number:

Email Address:

Diagnosis

Medical Details: Date of Diagnosis:

History/ Comments:

Weight: Height: Shoe Size:

Medical Device

Current Device Details: ☐ Right ☐ Left ☐ Both

Any problems with current device? ☐ No ☐ Yes If yes please specify:

Tell us what you would like us to help with:

Medical Device

What are your initial expectations regarding the assessment and any treatment we may provide?:

Any other relevant information:

How did you hear about Blatchford Private Clinic?:

Can we send you information in the future? ☐ No ☐ Yes

If yes, what is your preferred method? ☐ Post ☐ Email

General Health

Are you currently taking any medication? ☐ No ☐ Yes If yes please specify:

Are you diabetic? ☐ No ☐ Yes

Have you ever suffered from heart problems? ☐ No ☐ Yes

Do you suffer from high blood pressure? ☐ No ☐ Yes

Do you know of any infectious risks you are or may be suffering from e.g. MRSA or Hepatitis? ☐ No ☐ Yes

It is essential that you declare any condition that may be deemed a health risk to yourself or clinical staff.

If you answered yes to any of the questions above, please specify:

Are you happy for us contact your GP should we need to?: ☐ Yes ☐ No

GP's Name:

GP's Address & Post Code:

Consultant's Name:

Consultant's Address & Post Code:

Consent Form

Please complete the details below to consent to Blatchford Private Clinic obtaining relevant medical information to assist with your care.

I authorise Blatchford Private Clinic to contact my GP and hospital consultant involved in my treatment if required.

Name: Signature:

Address:

Date: