

THE PRACTICE

WELLBEING CENTRE



Zoe Roberston

Consent Form

Date of birth 12 Mar 2004

Practitioner Tiana Quaife

Appointment 10 Apr 2024, 4:00PM

Completed 18 Apr 2024, 8:15PM

Consent Form

First Name Zoe-Joy

Last Name Robertson

Gender Identity and Pronouns female, she/her

Full Address 2/9 Forest oak court, Chuwar, 4306

Mobile Number 0480320111

Date of Birth 12/03/2004

Email zoerobertson924@gmail.com

Are you a
☐ Torrens Student
☐ Torrens Staff
☒ Concession
☐ Student
☐ Other

Name of person in case of emergency Sharon Robertson

Relationship to client mother

How did you hear about The Practice Wellbeing Centre
☒ Referred by a friend
☐ Social Media
☐ Marketing Campaign
☐ Other

I give my permission to contacted via SMS or email for appointment reminder
☒ Yes
☐ No

Do you agree to being sent marketing material, promotions, newsletters?
☐ Yes
☒ No

Signature

Zoe-Joy

Date

17 Apr 2024

Name of Parent/Guardian if under 18

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Client Health Questionnaire

What is the main reason for today's visit?

my immunity.

Please list any medically diagnosed conditions here:

graves disease, mental health.

Are there any other health issues that we should be aware of?

Allergies

☒ Yes
☐ No

Food Intolerances

☐ Yes
☒ No

Heart Condition/High Blood Pressure

☐ Yes
☒ No

Medical Devices/Implant/Joint Replacement

☐ Yes
☒ No

Diabetes

☐ Yes
☒ No

Liver or Kidney Disease

☐ Yes
☒ No

Vegetarian/Vegan

☐ Yes
☒ No

Pregnant (or chance of pregnancy)

☐ Yes

☒ No

Breastfeeding

☐ Yes

☒ No

Medications/Supplements

List all medications or natural remedies you are currently taking (incl. Panadol, OCP etc)

Brand & Name

1) N-acetylcysteine, 2) Alkamin calm, 3) Carimazole, 4) Vitamin D3, 5) iron tables

Dose (how much and how often)

1) one scoop, 2) two scoops, 3) 5mg 3 tables at night, 4) two everyday, 5) every few days. Vitamin c daily, 6)

Reason for taking

for my immunity.

Since when?

Multiple timelines, please contact me if this information is needed.

Declaration: I understand that whilst I am not obliged to provide any information, failure to provide full health details requested above or during consultations may compromise the quality of treatment provided.

Client Signature

Zoe-Joy

Date

18 Apr 2024

Parent/Guardian signature if client is under 18 years of age


Please read the following and sign to indicate your understanding and declaration of consent:

- I am aware that this is a student teaching clinic and consent to the clinical assessment and treatment by student practitioners under the supervision of a qualified practitioner.
- I understand that at times the clinical supervisor may be observing, commenting or demonstrating during the consultation and/or treatment and that other students may also be observing during consultations in the room and via live streaming.
- I understand that in order that the student obtain as much experience as possible it may not always be possible to be seen by the same student practitioner at return visits.
- I understand that information provided during the consultation process may be used for training purposes by clinic students and staff and that all identifying details will be omitted in these instances to ensure patient confidentiality is maintained.
- I understand that physical therapy treatments may require an appropriate level of disrobing in order to carry out the appropriate treatment

and that during physical therapy treatments every effort will be made to make my experience as comfortable as possible and I will communicate any concerns or discomfort that I experience immediately.

- I understand that treatment conducted at The Practice Wellbeing Centre does not take the place of medical treatment where needed and it is my responsibility to inform the student practitioner of any illnesses, injuries, medical conditions or procedures and any other information regarding my health.
- I understand that my file notes will be available to each student practitioner I attend for treatment across all the modalities.
- I understand that whilst I am not obliged to provide any information, failure to provide full health details requested during consultations may compromise the quality of treatment provided.
- I understand that a 50% cancellation or no show fee may apply. The no-show policy allows for three instances and may result in suspension from the clinic for a year.
- I hereby acknowledge the terms and conditions of consultation and treatments at The Practice Wellbeing Centre as stated above and that information provided on this form is accurate, current and will be maintained in accordance with the Health Records Act (2001), National Privacy Principles and the Privacy Act (2001).
- I understand that I should notify my treating practitioners at The Practice Wellbeing Centre prior to undertaking more than one treatment modality on a single day.

Client Signature

A handwritten signature in black ink that reads "Zoe-Joy". The letters are cursive and connected, with a long horizontal stroke at the end of the "y".

Date

18 Apr 2024

**Parent/Guardian signature if client is under
18 years of age**