CUSTOM FOOT CLINIC PATIENT INTAKE

3 pages total

Please note there are *3 PAGES* to be completed!

Name: _____ Phone: _____ Date:_____

Address: _____City:_____ Postal Code:_____

Birthdate: _____Gender: _____Age: _____ Height: _____ Weight: _____

Medical Doctor: _____ Doctor address/ phone #: _____

Occupation: _____ Shoe Size: _____ Email: _____

What are the specific problems for which you seek treatment today? ie: reason for visit?

_____

Previous care by a chiropodist or podiatrist? ___ yes ___ no

If yes, when and why? _____

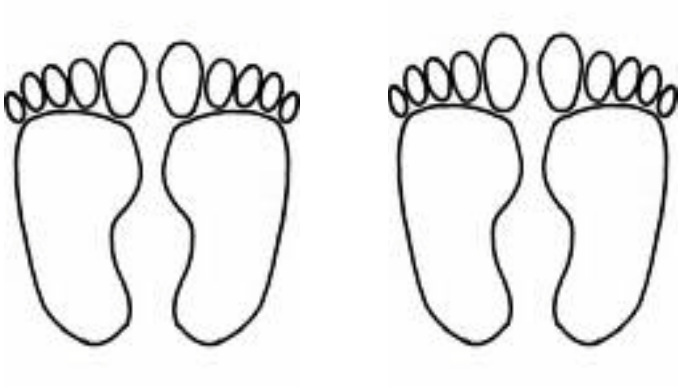
Where did you hear about our office?

___ friend/ family _____ ___ doctor: _____

___ newspaper ad ___ phone book/ yellow pages ___ online/ website other: _____

On the diagram below, please mark the areas on your legs and feet which best represent the pain/ sensation or problems you are having.

XX burning SS sharp/ stabbing ++ dull/ aching NN numbness PP pins/ needles



TOP **BOTTOM**

LEFT RIGHT LEFT RIGHT

Are there any other painful areas on your ankles, knees, legs, thighs, hips or back? If yes, please describe:_____

HEALTH HISTORY

Please check all items that specifically relate to your health history. Please answer these questions carefully, as they will be considered in establishing a suitable treatment plan for you.

Head, ears, eyes, nose and throat

__ frequent headaches __ ringing in ears __glasses/ contacts __ throat/ nose infections
__ head injury __ difficulty hearing __ vision problems __ dizziness
__ fainting spells other?: _____

Cardiovascular

__ high blood pressure __ heart disease __ chest pain/ angina __ heart attack
__ low blood pressure __ stroke __ bleeding problems __leg cramps
__ poor circulation __ varicose veins __ swollen ankles
other?: _____

Respiratory

__ shortness of breath __ asthma __ smoker; amount per day:_____
__ non-smoker; smoked in the past? If yes, how long? _____
Other?: _____

Endocrine

__ diabetes: how long? _____ is your diabetes controlled by: ___ insulin ___ pills ___ diet & exercise
__ thyroid problems __ kidney/ liver disease other?: _____

Musculoskeletal

__ osteoporosis __ muscle weakness __ fibromyalgia
__ osteoarthritis __ rheumatoid arthritis __ other arthritic diseases?: _____
__ joint pain __ joint stiffness __ joint swelling __ limited joint movement
Area: _____ Area: _____ Area: _____ Area: _____
Have you ever broken any bones? If yes, where?: _____
Other?: _____

Neurological

__numbness __ neuropathy __ convulsions/ seizures __ parkinsons disease
__multiple sclerosis __ post polio __ charcotmarie tooth
Other: _____

Skin and nails

__ dry/ cracking skin __ sensitive skin __ brittle/ dry skin __ psoriasis
__ sweaty skin __ rashes/ itching __ fungal infections __ discoloured nails
__ corns/ callus __ warts __ bruise easily __ foot/ leg ulcers
Other?: _____

Psychological

__ depression __ anxiety other?: _____

Surgery

__ foot surgery __ joint replacement __ organ transplant
Other?: _____

Allergies

Do you have any allergies – medicinal, food, environmental or other? _____

Other

Have you ever been hospitalized? Reason: _____

If there are any other relevant medical conditions not outlined on this form please outline here:

_____
_____

Medications

Please list any medications, prescription or otherwise that you are currently taking:

_____
_____
_____
_____

Have you ever experienced any side effects from local anaesthetics, penicillin or other medications?

_____

PLEASE INFORM THE CHIROPODIST IF YOU HAVE EVER TESTED POSITIVE FOR HIV OR HEPATITIS B, C or D

I acknowledge that the above information is correct. I understand that this information is confidential, and will be used for no other purpose than for the patient's medical record.
I hereby give permission for the exam, assessment and treatment of my foot conditions by the chiropodist.
I understand that in the practice of chiropody, as in all health care, there may be some slight risks to treatment. I wish to rely on the chiropodist to exercise judgement during the course exams and treatment that based on the facts known at the time, is in my best interests.
I have read the above consent and have had opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ _____ _____
Name Signature Date