Custom Foot Clinic & Orthotic Centre

Confidential Patient Intake Form

The information requested below must be completed accurately and in full to assist us in treating you safely.

Verified:

Name:		Today's Date (D/M/Y):
Address:	City:	Postal Code:
Home Ph.	Cell Ph.	Email:
Date of Birth (D/M/Y):	Age:	☐ Male ☐ Female
Occupation:	Employer:	
Medical Doctor:		
Height:	Weight:	Shoe Size:
Previous Foot Care? ☐ Yes ☐ No If yes, when & why?		

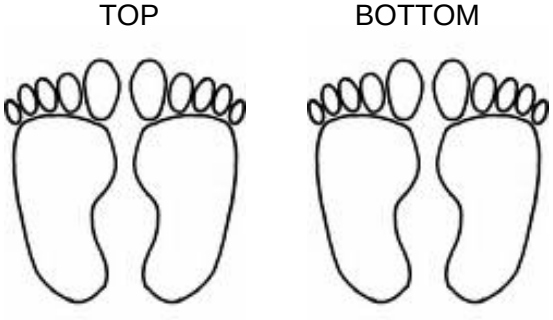
Current Complaint

Reason for Visit / Current Complaint(s)?

What do you believe caused this?

When did it occur?

TOP BOTTOM



LEFT RIGHT LEFT RIGHT

Mark area(s) of pain or unusual feeling on diagram.

NN Numbness

XX Burning

PP Tingling/Pins & Needles

SS Stabbing & Sharp

++ Dull & Aching

What makes it better?

What makes it worse?

Are there any other painful areas on your ankles, knees, legs, thighs, hips or back? Please describe:

Do you have problems walking? Please describe:

806 Gordon St. Guelph ON N1G1Y7

Medical History

Allergies

☐ Yes ☐ No

Please list:

_____

_____

Disease

- ☐ AIDS/ HIV
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
  - How long: _____
  - Controlled by:
    - ☐ insulin
    - ☐ pills
    - ☐ diet & exercise
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hepatitis A B C D
- ☐ Mental/ Emotional Difficulty
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Thyroid Trouble
- ☐ Tinnitus
- ☐ Tuberculosis TB
- ☐ Vertigo/ Dizziness
- ☐ Vision Loss

Cardiovascular & Lung

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack/ MI
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lung/ Breathing Issue
- ☐ Mechanical Heart Valve
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Smoker
  - Cigarettes per day ___
- ☐ Stroke/ TIA
- ☐ Swollen Ankles
- ☐ Varicose veins

Gastrointestinal

- ☐ Abrupt Weight Loss
- ☐ Abrupt Weight Gain
- ☐ Colitis
- ☐ Diverticulitis
- ☐ GERD/ GORD
- ☐ Hepatitis
- ☐ Irritable Bowel
- ☐ Ulcer

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ Sexual Dysfunction

Skin & Nails

- ☐ Bruise easily
- ☐ Corns/ Callus
- ☐ Discolored Nails
- ☐ Dry & Cracking Skin
- ☐ Eczema/ Psoriasis
- ☐ Fungal Infection
- ☐ Rash
- ☐ Psoriasis
- ☐ Skin Infection
- ☐ Sweaty Skin
- ☐ Ucers of Foot/ Leg
- ☐ Warts
- ☐ Other skin condition

Musculoskeletal

- ☐ Artificial Joint/ Pins/ Screws
- ☐ Bone Fracture
- ☐ Connective Tissue Disorder
- ☐ Dislocated Joint
- ☐ Fibromyalgia
- ☐ General Stiffness
- ☐ Weakness
- ☐ Leg Cramps
- ☐ Numbness/ Tingling
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Parkinson's
- ☐ Peripheral Neuropathy
- ☐ Multiple Sclerosis
- ☐ Scoliosis
- ☐ Slap Foot/ Drop Foot
- ☐ Spinal Disc Disease

☐ Other Medical Conditions Not Listed:

_____

_____

☐ Pregnant - Due Date:

_____

Have you **ever** had any major **surgeries or operations**? ☐ Yes ☐ No

If yes, please describe what and when:

Medications

Please list **all** prescription & non-prescription **medications** you are currently taking and the **reason** for them:

Have you ever experienced any side effects from local anaesthetics, penicillin or other medications? ☐ Yes ☐ No

806 Gordon St. Guelph ON N1G1Y7

How did you hear about our office or who referred you?

☐ Google ☐ Sunlife/Lumino ☐ Yellowpages

☐ Patient / Family / Friend _____

☐ Health Professional _____

☐ Other _____

Office Policies & Consent

FEES
It is the policy of this clinic that payment is required at the time that services are rendered.
No credit or accumulation of fees is permitted.
Cash, Cheque, Credit or Debit is accepted. All NSF cheques will be charged a $30 fee.

MISSED APPOINTMENTS & ASSOCIATED FEE
Reminder calls/emails are a courtesy provided by the clinic. However, remembering your appointment is your responsibility.
If you are unable to keep an appointment, 24 hours cancellation notice is required.
Without 24 hours prior notification, you will be billed a cancellation fee.

EXTENDED HEALTH CARE COVERAGE
Many extended health care insurance plans cover therapy. Check with your employer for details.
Fees recovered from extended health insurance plans are the patient's responsibility.
If other financial arrangements are required, please discuss them with your individual therapist prior to your treatment.
I clearly understand and agree that ALL services rendered to me are charged directly to me and that I am personally responsible for payment.

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.

I have read and acknowledged all of the above information.

I have completed honestly, accurately and in full this patient intake form and understand the importance of informing my Chiropodist of any changes.

Patient Signature: _____ Date: _____