

CUSTOM FOOT CLINIC & ORTHOTIC CENTRE PATIENT INTAKE

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:? Please describe as accurately as possible: _____

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

If yes, when and why? _____

Where did you hear about our office?

friend/ family _____ doctor: _____ why did you choose us? _____

google/ online ___ how can we improve our website? _____

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

LEFT

RIGHT



BOTTOM

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 charcot marie 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?: _____

