



## 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation:		Employer:	
Medical Doctor:			
Height:	Weight:	Shoe Size:	
Previous Foot Care? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, when & why?			

Current Complaint			
Reason for Visit / Current Complaint(s)?			
What do you believe caused this?			When did it occur?
<p>TOP</p>  <p>LEFT    RIGHT</p>	<p>BOTTOM</p>  <p>LEFT    RIGHT</p>	<p>Mark area(s) of pain or unusual feeling on diagram.</p> <p><b>NN</b> Numbness</p> <p><b>XX</b> Burning</p> <p><b>PP</b> Tingling/Pins &amp; Needles</p> <p><b>SS</b> Stabbing &amp; Sharp</p> <p><b>++</b> Dull &amp; Aching</p>	<p>What makes it better?</p> <hr/> <p>What makes it worse?</p>
Are there any other painful areas on your ankles, knees, legs, thighs, hips or back? Please describe:			
Do you have problems walking? Please describe:			

<b>Medical History</b>			
<p><b>Allergies</b>  <input type="checkbox"/> Yes   <input type="checkbox"/> No            Please list:            _____            _____</p> <p><b>Disease</b>  <input type="checkbox"/> AIDS/ HIV  <input type="checkbox"/> Bleeding Disorder  <input type="checkbox"/> Cancer  <input type="checkbox"/> Diabetes                How long: _____                Controlled by:                    <input type="checkbox"/> insulin                    <input type="checkbox"/> pills                    <input type="checkbox"/> diet &amp; exercise  <input type="checkbox"/> Epilepsy  <input type="checkbox"/> Fainting  <input type="checkbox"/> Headache  <input type="checkbox"/> Hearing Loss  <input type="checkbox"/> Hepatitis A B C D  <input type="checkbox"/> Mental/ Emotional Difficulty  <input type="checkbox"/> Polio  <input type="checkbox"/> Rheumatic Fever  <input type="checkbox"/> Thyroid Trouble  <input type="checkbox"/> Tinnitus  <input type="checkbox"/> Tuberculosis TB  <input type="checkbox"/> Vertigo/ Dizziness  <input type="checkbox"/> Vision Loss</p>	<p><b>Cardiovascular &amp; Lung</b>  <input type="checkbox"/> Anemia  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> COPD  <input type="checkbox"/> Emphysema  <input type="checkbox"/> High Cholesterol  <input type="checkbox"/> Heart Disease  <input type="checkbox"/> Heart Attack/ MI  <input type="checkbox"/> High Blood Pressure  <input type="checkbox"/> Low Blood Pressure  <input type="checkbox"/> Lung/ Breathing Issue  <input type="checkbox"/> Mechanical Heart Valve  <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Shortness of Breath  <input type="checkbox"/> Smoker                Cigarettes per day ____  <input type="checkbox"/> Stroke/ TIA  <input type="checkbox"/> Swollen Ankles  <input type="checkbox"/> Varicose veins</p>	<p><b>Gastrointestinal</b>  <input type="checkbox"/> Abrupt Weight Loss  <input type="checkbox"/> Abrupt Weight Gain  <input type="checkbox"/> Colitis  <input type="checkbox"/> Diverticulitis  <input type="checkbox"/> GERD/ GORD  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Irritable Bowel  <input type="checkbox"/> Ulcer</p> <p><b>Genitourinary</b>  <input type="checkbox"/> Kidney Disease  <input type="checkbox"/> Prostate Disease  <input type="checkbox"/> Sexual Dysfunction</p> <p><b>Skin &amp; Nails</b>  <input type="checkbox"/> Bruise easily  <input type="checkbox"/> Corns/ Callus  <input type="checkbox"/> Discolored Nails  <input type="checkbox"/> Dry &amp; Cracking Skin  <input type="checkbox"/> Eczema/ Psoriasis  <input type="checkbox"/> Fungal Infection  <input type="checkbox"/> Rash  <input type="checkbox"/> Psoriasis  <input type="checkbox"/> Skin Infection  <input type="checkbox"/> Sweaty Skin  <input type="checkbox"/> Ucers of Foot/ Leg  <input type="checkbox"/> Warts  <input type="checkbox"/> Other skin condition</p>	<p><b>Musculoskeletal</b>  <input type="checkbox"/> Artificial Joint/ Pins/ Screws  <input type="checkbox"/> Bone Fracture  <input type="checkbox"/> Connective Tissue Disorder  <input type="checkbox"/> Dislocated Joint  <input type="checkbox"/> Fibromyalgia  <input type="checkbox"/> General Stiffness  <input type="checkbox"/> Weakness  <input type="checkbox"/> Leg Cramps  <input type="checkbox"/> Numbness/ Tingling  <input type="checkbox"/> Osteopenia  <input type="checkbox"/> Osteoporosis  <input type="checkbox"/> Osteoarthritis  <input type="checkbox"/> Rheumatoid Arthritis  <input type="checkbox"/> Parkinson's  <input type="checkbox"/> Peripheral Neuropathy  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Scoliosis  <input type="checkbox"/> Slap Foot/ Drop Foot  <input type="checkbox"/> Spinal Disc Disease</p> <p><input type="checkbox"/> Other Medical Conditions Not Listed:            _____            _____</p> <p><input type="checkbox"/> Pregnant - Due Date:            _____</p>
<p>Have you <b>ever</b> had any major <b>surgeries or operations</b>?   <input type="checkbox"/> Yes   <input type="checkbox"/> No            If yes, please describe what and when:</p>			

<b>Medications</b>
<p>Please list <b>all</b> prescription &amp; non-prescription <b>medications</b> you are currently taking and the <b>reason</b> for them:</p>
<p>Have you ever experienced any side effects from local anaesthetics, penicillin or other medications?   <input type="checkbox"/> Yes  <span style="float: right;"><input type="checkbox"/> No</span></p>

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 chiroprapist.  
I understand that in the practice of chiroprapy, as in all health care, there may be some slight risks to treatment. I wish to rely on the chiroprapist 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 Chiroprapist of any changes.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_