

PERSONAL INFORMATION

First Name : _____ Last Name : _____

Address : _____

City : _____ Province : _____ Postal Code : _____

Phone (Home) : _____ Phone (Business) : _____

Phone (Cell) : _____ E-Mail : _____

Age : _____ Date Of Birth : _____ / _____ / _____
Month Day Year

Occupation : _____

Emergency Contact : _____ Phone : _____

Your Family Physician : _____ Phone : _____

Reason for Visit : _____

Your Height : _____ Weight : _____ Shoe Size : _____

How much are you on your feet in an average day? 20% 40% 60% 80% 100%

Athletic activities and frequency : _____

What type of shoes do you wear most often (list) : _____

Do you wear slippers / shoes at home? Yes No Do you wear orthotics? Yes No

How often do you replace your shoes? 6 Months Yearly Longer?

Have you ever seen a chiropodist/podiatrist? Yes No When? : _____

What was the reason? : _____

Are you allergic to : Local Anesthetic Iodine Cortisone Tape/Adhesives

Please list any other allergies : _____

Please list current medications : _____

Previous surgeries : _____

Hospitalizations : _____

HEALTH INFORMATION

Have you been diagnosed with any of the following?

- | | | | | | |
|-----------------------------|---------------------------|--------------------------|----------------------------|---------------------------|--------------------------|
| Rheumatoid Arthritis | <input type="radio"/> Yes | <input type="radio"/> No | Osteoarthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Gout | <input type="radio"/> Yes | <input type="radio"/> No | Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No | Stroke or ML | <input type="radio"/> Yes | <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | Bleeding Disorders | <input type="radio"/> Yes | <input type="radio"/> No |
| High Cholesterol | <input type="radio"/> Yes | <input type="radio"/> No | Breathing Disorders | <input type="radio"/> Yes | <input type="radio"/> No |
| Hepatitis | <input type="radio"/> Yes | <input type="radio"/> No | HIV/Aids | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart Condition | <input type="radio"/> Yes | <input type="radio"/> No | Skin Disorder | <input type="radio"/> Yes | <input type="radio"/> No |

If yes to any of the above please explain the nature of the condition :

Do you drink alcohol? Yes No How much? : _____ How often? : _____
 Do you smoke? Yes No How much? : _____ How long? : _____

How did you hear about the clinic? (If newspaper, which one?) : _____

Friend / Phone Book / Doctor / Other Clinic / Radio / Internet / Other : _____

Patient's consent (must be filled out and signed):

- I understand that there will be a fee charge for all missed appointments
- I understand there is a non-refundable deposit on orthotics / surgeries / braces / stockings
- I certify that the above information provided on the intake form is complete and true to the best of my knowledge
- I give permission for my chiropodist to photograph my feet and gather health information from time to time for the purposes of maintaining my patient record
- I give my permission to the attending chiropodist to administer and perform such procedures as may be deemed necessary in the treatment of my feet
- I give my permission to the chiropody clinic to contact my doctor for any pertinent information relating to the treatment of my feet
- I give my permission to the chiropody clinic to send reports and photos to my doctor regarding my ongoing foot management
- I understand that chiropody services are not covered by OHIP and that I am financially responsible for all charges whether or not my third party insurance covers the cost
- I give my permission to the chiropody clinic to call my home for appointment reminders and annual check-ups

CONTACT INFORMATION

1557 Highland Rd, W. Suite 201,
Kitchener, ON, N2N 3K4

kwfootclinic.com 519-884-4200
office@kwfootclinic.com 519-884-4290 (Fax)

Patient Signature

Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We follow all provincial privacy laws as well as the bi-laws of the Ontario College of Chiropodists and promise to treat your personal information with the strictest of respect.