Foot Medical Centre
Your Family Foot Specialist and Orthotic Provider

# Patient Intake Form

Date of Visit: __DD__ /__MM__ /__YYYY__

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Initial: _____

Date of Birth: _____ /____ /_____ Age: _____ Gender: ☐ Male ☐ Female
DD MM YYYY

Address: _____

City: _____ Province: _____ Postal: _____

Home Phone: (____) ____ - _____. ☐
Cell Phone: (____) ____ - _____. ☐ Preferred Contact
Work Phone: (____) ____ - _____. ☐

**@ Email Address:** _____

## EMERGENCY CONTACT

Name: _____ Phone: (____) ____ - _____. Relationship: _____

## PHYSICIAN INFORMATION

Doctor: _____ City: _____ Phone: (____) ____ - _____.

## HEALTH CARE / INSURANCE PLAN

**Do you have health care benefits?** ☐ Yes ☐ No ☐ Unknown ☐ ODSP ☐ OW ☐ Other: _____

Insurance Company: _____ Policy Number: _____

## GENERAL INFORMATION

**Employment Status:** ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other: _____

**Occupation:** _____

**Amount of time on feet per day (hours):** ☐ 0-4 ☐ 4-8 ☐ 8-12 ☐ 12-16 ☐ 16+

**Height:** _____ **Weight (lbs):** _____ **Shoe Size:** _____ ☐ Narrow ☐ Wide

**Type of footwear usually worn…**

Outside: ☐ Running/Walking ☐ Casual ☐ Work boots ☐ Heels ☐ Flats ☐ Sandals ☐ Other: _____

Inside: ☐ Running/Walking ☐ Casual ☐ Work boots ☐ Heels ☐ Flats ☐ Sandals ☐ Other: _____

Work: ☐ Running/Walking ☐ Casual ☐ Work boots ☐ Heels ☐ Flats ☐ Sandals ☐ Other: _____

## HOW DID YOU HEAR ABOUT US?

☐ Google / Search Engine
☐ Our Website
☐ Facebook / Social Media
☐ Physician
☐ Pharmacist
☐ Family / Friend
☐ Newspaper: _____
☐ Flyer / Pamphlet
☐ Signage / Walk by
☐ Phone Book / Yellow Pages
☐ Home Show
☐ Other: _____

TURN PAGE OVER TO CONTINUE…

## MEDICAL HISTORY

**Are you currently…** ☐ Pregnant ☐ Nursing ☐ N/A Weeks: ☐ 1-12 ☐ 13-28 ☐ 29-40

**Have you been diagnosed OR treated for…**

☐ **Diabetes**: ☐ Type 1 ☐ Type 2 ☐ Pre-Diabetes ☐ Gestational Year Diagnosed: _____

Blood Glucose Level: _____ HbA1C %: _____

☐ **Arthritis**: ☐ Osteo ☐ Rheumatoid ☐ Psoriatic ☐ Reactive ☐ Ankylosing Spondylitis ☐ Other: _____

| | | | |
|---|---|---|---|
| ☐ Alzheimer's | ☐ Emphysema | ☐ Liver Disease | ☐ Psoriasis |
| ☐ Anemia | ☐ Fibromyalgia | ☐ Lupus | ☐ Seizure / Epilepsy |
| ☐ Anxiety | ☐ Headaches / Migraines | ☐ Multiple Sclerosis | ☐ Schizophrenia |
| ☐ Asthma | ☐ Heart Problems | ☐ Muscular Dystrophy | ☐ Shortness of Breath |
| ☐ Bleeding Disorder | ☐ Hepatitis A/B/C | ☐ Osteoporosis | ☐ Stomach / Bowel Trouble |
| ☐ Blood Clot Disorder | ☐ High / Low Blood Pressure | ☐ Pacemaker | ☐ Stroke |
| ☐ Cancer | ☐ High Cholesterol | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Depression | ☐ HIV / AIDS | ☐ Parkinson's | ☐ Tuberculosis |
| ☐ Eczema / Dermatitis | ☐ Kidney Disease | ☐ Polio / Poliomyelitis | ☐ Vision Loss |
| | | | ☐ Other: _____ |

Notes: _____

_____

## MEDICATION LIST

Please list all **current** prescription and OTC medications you take…
☐ See drug list provided

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you take a **blood thinner** (Aspirin, Coumadin)? ☐ Yes ☐ No
Do you take **contraceptive/birth control**? ☐ Yes ☐ No
Do you consume **Alcohol**? ☐ Yes ☐ No ☐ Previous Use
Do you **smoke**? ☐ Yes ☐ No ☐ Previous Use

## ALLERGIES

☐ No Known Allergies
☐ Penicillin, Sulpha, Erythromycin
☐ Local Anesthetics (Xylocaine)
☐ NSAID's (Advil, Tylenol, Aspirin)
☐ Narcotics (Morphine, Codeine, Demerol)
☐ Adhesive Tapes / Band-Aids
☐ Latex / Silicone
☐ Environmental (Pollen, Dust, Grass)
☐ Food (Peanuts, Fish, Gluten)
☐ Other: _____

Type of Reaction: ☐ Mild ☐ Moderate ☐ Anaphylaxis

## FOOT MEDICAL HISTORY

**Have you worn Custom Made Orthotics?** ☐ Yes ☐ No **Did they provide relief?** ☐ Yes ☐ No

**Have you experienced any of the following foot / lower limb problems…**

| | | | | |
|---|---|---|---|---|
| ☐ Ankle Injury / Sprain | ☐ Swelling | ☐ Fungal Nails | ☐ In-Toeing | ☐ Runners/Jumpers Knee |
| ☐ Amputation(s) | ☐ Cramps | ☐ Gout | ☐ Itchy Feet | ☐ Sweaty Feet |
| ☐ Athletes Foot | ☐ Dry, Cracked Skin | ☐ Hammertoes | ☐ Knee Pain | ☐ Ulcers |
| ☐ Lower Back Pain | ☐ Flat Feet | ☐ Heel Pain | ☐ Neuroma | ☐ Varicose Veins |
| ☐ Corns / Callous | ☐ Forefoot Pain | ☐ High Arches | ☐ Neuropathy | ☐ Warts |
| ☐ Bunion / Bunionette | ☐ Fracture(s) | ☐ Ingrown Toenails | ☐ Numbness | ☐ Other: _____ |

Notes: _____

_____

**What brings you to Foot Medical Centre today?**

_____

_____

_____

PLEASE RETURN THIS FORM TO THE RECEPTIONIST

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Your Family Foot Specialist and Orthotic Provider

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# Patient Consent for Collection, Use and Disclosure of Personal Information Form

Welcome to Foot Medical Centre; Your Family Foot Specialist & Orthotic Provider.

Below is a summary of Foot Medical Centre's privacy policy, which ensures that:

1. Only necessary information is collected about you;
2. We only share your information with your consent;
3. The storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
4. Our privacy protocols comply with legislation, standards of our regulatory body, the College of Chiropodists of Ontario, and the law.

## Summary of Use(s), Collection and Disclosure of Personal Information at Foot Medical Centre

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality of service
- To assess your healthcare needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to chiropody care generally
- To advise you of special events or opportunities
- To advise you that a product or service should be reviewed
- To communicate with other treating health care providers, including specialists and referring health care practitioners (e.g. family physician)
- To allow us to maintain communication and contact with you to book and confirm appointments
- To allow us to efficiently follow up for treatment, care and billing
- For teaching, research, demonstration purposes on an anonymous basis
- To complete and submit chiropody claims for third-party adjudication and payment
- To comply with the legal and regulatory requirements of the College of Chiropodist of Ontario, according to the provisions of the Regulated Health Professions Act by MoHLTC
- To permit potential purchasers, practice brokers or advisors to evaluate and conduct an audit in preparation for the sale of the chiropody practice
- If applicable to deliver your charts and records to the chiropodist's insurance to enable the insurance company to assess liability and quantify damages
- To prepare material for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

Foot Medical Centre employees consists of Chiropodists, Chiropody students and support staff. All Foot Medical Centre employees are trained in the appropriate use(s) and protection of the information that you disclose. We utilize external services that may, in the course of their duties, have limited access to personal information withheld. These services include computer consultants, office security personnel, maintenance, cleaners, bookkeepers, accountants, temporary office workers, credit card companies, website managers and lawyers. We restrict their access to personal information withheld as much as possible. We also have their assurance that they also follow appropriate privacy policies and will not disclose your information.

By signing Foot Medical Centre's Patient Consent Form, you consent to the collection, use and/or disclosure of your personal information for the aforementioned purposes. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. You may refuse consent for the use and/or disclosure of your personal information, and will be explained the process and ramifications of that decision.

I, the undersigned, consent to the collection, use and/or disclosure of my personal information, by Foot Medical Centre, for the aforementioned purposes.

_____ _____

Signature of Patient or Guardian | Patient Name (Print)

_____ _____/_____/_____

Witness Signature | Date (mm/dd/yyyy)