Patient Information

First Name: ______________________ Last Name: ______________________

Sex: M / F Post Code:______________ Date of Birth: ______________________

Address:______________________ Home No.: ______________________

City: ____________ Province: ________ Work No.: ______________________

E-mail: ______________________ Cell No.: ______________________

Family Doctor: ______________________ Family Doctor No.: ______________

Family Doctor Address: ____

Emergency Contact Name: ______________ Emergency Contact No.: ____________

Relationship to Patient: __________ Marital Status: □ Single □ Married □ Widowed

Spouse/Partner Name: __________ □ Partner □ Divorced

Employer/School: ______________________

Please provide a copy of your insurance card to our staff. If the card is not in your name:

Insurance Policy Holder Name: ______________________ Policy No.: ______________

Shoe size:______________ Height:______________ Weight:______________

What type of shoes do you wear most often? ______________________________

What shoes (if any) do you wear at home? ______________________________

Current occupation or grade in school: ______________________________

Do you stand or sit at work? __________

Are you allergic or sensitive to?

□ Penicillin □ Sulfa □Tape □Latex □ Betadine (iodine) □ Aspirin □ NONE

□Tylenol™ □ Ibuprofen □ other (specify)

Please check any of the following conditions that you are currently experiencing or suffering from:

□ Flat feet

□ Feet/ toes feel numb

□ Foot/toes/legs burn

□ Pale or blue discoloration of the feet

□ Heel or arch pain

□ Pain in feet or heels when getting out of bed

□Non/poor healing sore, ulcer, or gangrene on the Leg or foot

□ Pain or fatigue of feet or legs in activity or exercise

□ Ankle instability (easy twisting injuries)

□ Ankle swelling or stiffness

□ Achilles tendon pain

□ Leg pain (shin splints)

□ Coldness in the legs or feet that is uncomfortable

□ Back pain

□ Neck pain

□ Poor coordination

□ Absent or decreased pedal pulses

□ Difficulty/pain with brisk walking or running occurring with some distance

(This pain is relieved by rest: yes / no)

What is the reason for your visit today? ______________________________

____

Please turn over →

How long has this bothered you? **Days / Weeks / Months / Longer**

What treatments have you tried & have they been effective? ______________________________________

____

Is this condition causing or are you suffering with any of the following:

Tingling/numbness in:	**Pain radiating into:**	**Weakness of the:**	**Difficulty with:**	
□ Legs R / L	□ Ankle R / L	□ Legs R / L	□ Standing	□ Bending
□ Ankle R / L	□ Feet R / L	□ Ankle R / L	□ Walking	□ Lifting
□ Feet R / L	□ Toes R / L	□ Foot R / L	□ Sitting	□ Kneeling

Medical History

Current medications prescribed by a doctor or over-the-counter: ______________________________________

____

____

Please indicate if you have a problem with any of the following:

□ Alcoholism □ Blood disorders □ Gout □ Liver □ Sleep apnea

□ Allergies □ Breathing problems □ Heart disease □ Musculoskeletal □ Stomach/bowel

□ Arthritis (specify) □ Circulation problems □ Heart murmur □ Neurological (specify) ____________________

□Thyroid (specify) __________________ □ Depression/anxiety □ High blood pressure

□ Asthma □ Mental Illness □ High cholesterol □ Skin disorders (specify) ____________________

□ Diabetes (type 1, type 2) □ Kidney □ Blood clot/DVT/PE

Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

□ Yes □ No Do you have any artificial joints? Where? ___________________________________

□Yes □No Have you ever had any surgical procedures on foot/ankle or anywhere else on the body?

If yes, please describe: ____

□ Yes □ No Do you have an artificial heart valve?

Family History Is there any family history (blood relative) of: (Please indicate family member)

□ Arthritis ________________ Type________________ □ Cancer _________________ Type ______________

□ Bleeding disorders ___________________________ □ Circulation problems _____________________

□ Blood clot/DVT ______________________________ □ Diabetes __________________________________

□ Bunions ______________________________________ □ Flatfeet __________________________________

□ Hammer toes _________________________________ □ Heart disease ______________________________

□ Neurological _________________________________ □ Strokes___________________________________

□ Other (specify): _______________________________

Social History

Do you smoke? □ Yes □ No If yes: □ ½ ppd □ 1ppd □ 1 ½ ppd □ 2ppd

Did you smoke in past? □ Yes □ No If yes, how many years did you smoke? ____________

Do you drink alcohol? □ Yes □ No If yes: □ Socially □ 1 daily □ 2 daily □> 2 daily