Patient Information

First Name: ______________________ Last Name: ______________________

Gender: ______________ Date of Birth: ______________________

Address: ______________________ Home No.: ______________________

City: ______________ Province: __________ Work No.: ______________________

Post Code: ______________

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 □ Partner □ Divorced

Spouse/Partner Name: ______________

Employer/School: ______________________

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 □Tylenol™ □ Ibuprofen

□ Other (specify)______________ □ **NONE**

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)

Please turn over →

What is the reason for your visit today?____

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	□	Asthma	□	Sleep apnea	□	Stomach/bowel	□	Heart murmur
□	Allergies	□	Kidney	□	Gout	□	Musculoskeletal	□	Depression/anxiety
□	Blood disorders	□	Blood clot/DVT/PE	□	Liver	□	Circulation problems	□	Other Mental Illness
□	Breathing problems	□	Diabetes (type 1, type 2)	□	Heart disease	□	High cholesterol	□	High blood pressure

□ Arthritis (specify) ____

□ Neurological (specify) ____

□ Thyroid (specify) ____

□ Skin Disorders (specify) ____

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