Premier Care Physiotherapy

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# PATIENT INTAKE FORM

**How did you hear about us?**

☐ Internet ☐ Physician ☐ Friend ☐ Co-worker ☐ Other: Specify: ________________
☐ Family ☐ Sign ☐ Walk-in ☐ Newspaper

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr. Date: ______________________________

First Name: ___________________________ Last Name: ___________________________

Date of Birth (DD/MM/YYYY): ______________ E-mail: ______________________________

Do you give consent to receive emails from our clinic?
Yes No

Address: Street_________________________________________Apt. # ________________

City:__________________________________Postal Code: ___________________________

Occupation:_____________________________ Place of Employment: ________________

Home Phone #:______________Cell Phone#:______________Business Phone #:____________

Family Doctor Name:_______________________ Family Doctor Phone # ________________

Family Doctor Address: ____________________________________________________

Referring Doctor: _________________________________________________________

## REASON FOR VISIT

What is your main foot complaint? Explain in detail. ________________________________

______________________________________________________________________

Have you seen a Chiropodist/Podiatrist before? ☐ Yes ☐ No

If yes, for what condition?_________________________________When?__________________

Type of shoes worn daily ____________________________________________________

**ALLERGIES** (specify) _____________________________________________________

**CURRENT COMPLAINT** (Please check)

☐ Assessment/General Check-up
☐ Calluses
☐ Warts
☐ Fungal Toenails
☐ Thick Toenails
☐ Diabetic Footcare
☐ Bunions
☐ Ulcer
☐ Ingrown Toenail
☐ Ingrown Toenail Surgery
☐ Compression Stockings
☐ Athlete's Foot
☐ Heel Pain
☐ Painful Feet
☐ Flatfeet
☐ High Arched Foot
☐ Pain in the ball of the foot
☐ Arch Pain
☐ Varicose Veins
☐ Orthotics

**AGGRAVATED BY**

☐ Walking
☐ Standing
☐ Physical Activity In the morning
☐ After Rest

## Please Check

☐ **Good General Health**

**ENDORCRINE**
☐ Diabetes (type 1) for # of yrs: ________
☐ Diabetes (type 2) for # of yrs: ________

☐ Thyroidism
☐ Osteoporosis

**MUSCULOSKELETAL**
☐ Back Conditions
☐ Gout
☐ Osteopenia
☐ Neuromuscular disorder ______________
______________________________
☐ Psychological ______________________

☐ Osteoarthritis ______________________________
☐ Rheumatoid Arthritis ______________________________
☐ Fracture. Where? ______________________________

**DERMATOLOGICAL**
☐ Psoriasis
☐ Eczema
☐ Fungal
☐ Other: ______________
________________________

**RESPIRATORY**
☐ Asthma
☐ Bronchitis
☐ COPD

**CARDIAC**
☐ Hypertension (High Blood Pressure)
☐ High Cholesterol
☐ Congestive Heart Failure
☐ Poor Circulation
☐ Varicose Veins
☐ Angina
☐ Myocardial Infarction (Heart Attack) ______________________________
☐ Other:______________________________________________
______________________________________________

**BRAIN & NERVOUS SYSTEM DISORDER**
☐ Stroke
☐ Epilepsy
☐ Other: ______________________________

**OTHER MEDICAL CONDITIONS**
______________________________

| MEDICATIONS | FOR | PAST SURGERIES | YEAR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## FEES ARE NOT COVERED BY OHIP

**PATIENT'S CONSENT**
I give my consent to examination and treatment by the Chiropodist.
I give my consent to the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.
I understand that I am financially responsible for all charges whether covered by my health insurance plan or not.
I understand that service fees are payable at the time service is provided.

**"CANCELLATION POLICY"**
We try to provide exceptional service to our patients. To help us achieve this, we ask that you provide us with at least 24 business hours' notice if you need to reschedule or cancel your appointment, otherwise a 40$ no show fee will apply.
Thank you for your consideration!

Patient's Signature:______________________________Date: ______________________

Signature of Witness: ______________________________Date: ______________________