NIAGARA FOOT CARE CLINIC
AND ORTHOTIC CENTRE

270 Main St. E., Unit 5
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*****Online Intake Forms*****

Today's Date: _____

First Name: _____ Last Name: _____

Preferred Name: _____ Birthdate (D/M/YY): _____

Address: _____
(Street) (Apt)

_____
(City) (Postal Code)

Phone: (Home) _____ (Cell) _____

(Business) _____ (Other) _____

Employer: _____ Occupation: _____

Would you like to receive email correspondence?

☐ Yes ☐ No Email: _____

☐ Appointment reminders ☐ Financial documents ☐ Clinic newsletter
If yes, Check box for type of email correspondence you would like to receive?

Family Doctor: _____ Address: _____

In case of emergency, contact: _____

Relationship: _____ Phone: _____

Do you have Extended Health Care Coverage?

Policy Holder's Name: _____ Policy Holder's Birthdate: _____
(If different from patient)

Insurance Provider: _____ Employer's Name: _____

Plan number: _____ ID number: _____

How did you hear about our clinic? ☐ Phone Book ☐ Clinic Sign ☐ Website ☐ Friend/Relative/Doctor

Referral (Name): _____

Name: _____ Date: _____

Reason for today's visit: _____

When did your concern start? _____

Have you seen any other healthcare practitioner for the same concern? _____

Have you taken any medication or remedies to help with the concern? _____

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

If yes, Name of Practitioner: _____ Date of Last visit: _____

Have you had custom made orthotics previously? Yes ☐ No ☐

If yes, Name of clinic: _____ Date of Last visit: _____

Do you currently wear compression stockings (socks)? Yes ☐ No ☐

MEDICAL HISTORY

Height: _____ Weight: _____ Shoe size: _____

****

If you have been diagnosed with Diabetes/Borderline Diabetes, please answer the following:
Please Circle: **Type 1** or **Type 2** Date diagnosed? _____
What are your casual blood glucose levels: AM: _____ PM: _____ Average: _____
Do you feel Numbness/Tingling/Burning sensation in your feet or toes? Yes ☐ No ☐

****

Please indicate if you have, or have had, any of the following:

☐ AIDS/HIV	☐ Depression	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Kidney Problems	☐ Shortness of Breath
☐ Back Problems	☐ Epilepsy	☐ Liver Problems	☐ Stomach Ulcers
☐ Bleeding Disorder	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Cancer	☐ Heart Attack,	☐ Osteoarthritis	☐ Tuberculosis
☐ Cholesterol	Year: _____	☐ Parkinson's disease	☐ Other: _____
☐ Circulatory Problems	☐ Heart Disease	☐ Rheumatoid Arthritis	
☐ Cerebral Palsy	☐ Hepatitis A, B or C		

ALLERGIES

☐ Adhesive Tape	☐ Sulfa	☐ Local Anesthetics
☐ Iodine	☐ Aspirin	☐ Penicillin

Other: _____

Do you smoke? Yes ☐ No ☐ Years: _____ Qty/Day: _____
Do you consume alcohol? Yes ☐ No ☐ Frequency: _____
Are you slow to heal after cuts? Yes ☐ No ☐
Do you bruise easily? Yes ☐ No ☐
Are you currently pregnant or nursing? Yes ☐ No ☐ N/A ☐

Surgeries (Back, Hip, Knee, Ankle, Foot):_____

_____

Hospital where surgeries performed: _____

Medications (include vitamins and oral contraceptives):_____

_____