Woodbridge Avenue Chiropractic & Wellness Centre

53 Woodbridge Ave. Unit 4

Woodbridge, ON L4L 9K9

Tel: 905-264-8107

Chiropody Services

PATIENT INTAKE FORM

Date of Initial Visit: _____

PATIENT IDENTIFICATION			
First Name	Last Name	Date of Birth / / mm dd yyyy	Sex M / F

Address Street: City: Postal Code:	Home Phone: Cell Phone: Email: Referred By:
Emergency Contact: Name Relationship Phone	Family Physician: Address Phone Fax

SOCIAL HISTORY

Occupation		Footwear Typically Worn
Alcohol Consumption	Yes / No / Quit since Frequency:	Exercise Frequency and Duration
Smoking	Yes / No / Quit since Frequency: # of years:	Height Weight Shoe Size
Medications		Allergies

FAMILY HISTORY

Have any of your family members had: (If yes, please specify)

Diabetes

Arthritis

Foot Problems

MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? Please check all that apply.

DIABETES ☐

Type:

Year Diagnosed:

Blood Sugar Levels:

Last HgA1C:

ARTHRITIS

Rheumatoid Arthritis ☐

Osteoarthritis ☐

Psoriatic Arthritis ☐

Gout ☐

Other:

HEART CONDITIONS

Heart Attack ☐

Angina/Chest Pain ☐

Congestive Heart Failure ☐

High Blood Pressure ☐

High Cholesterol ☐

Anemia ☐

Bleeding Disorders ☐

Other:

COMMUNICABLE DISEASES

HIV / AIDS ☐

Hepatitis A / B / C ☐

Skin Conditions ☐

Psoriasis ☐

Eczema ☐

Skin Cancer ☐

Other:

MUSCULOSKELETAL CONDITIONS

Stroke ☐

Multiple Sclerosis ☐

Muscular Dystrophy ☐

Polio ☐

Epilepsy ☐

Osteoporosis ☐

Other:

PSYCHOLOGICAL CONDITIONS

Depression ☐

Anxiety ☐

Sleeping Disorders ☐

Other:

Other (please specify):

Please list any surgeries, injuries, and fractures:

FOOT HISTORY

Previous Foot Care

Previous Orthotics/OTC Insoles

History of Foot Problems

What is your reason for visiting us today?

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CONSENT FORM

COLLECTING PERSONAL INFORMATION

In order to provide you with the best possible care, we will require some of your personal information. The personal information to be collected includes: identifying data, medical history, and pictures/videos. Your personal information will be kept strictly confidential unless you have provided consent for us to disclose your information. The information collected will only be available to the chiropodist, receptionist, and any other individuals approved by you.

CONSENT TO TREATMENT

At each visit, the chiropodist will assess your condition before recommending a treatment, which will be explained to you. You are welcome to ask questions regarding your condition and treatment options until you achieve a good understanding of both. The chiropodist will not proceed with any treatment without your consent. If you are uncomfortable with the treatment, you reserve the right to terminate treatment at any time.

I, _____, understand and agree to the above and authorize Woodbridge Avenue Chiropractic & Wellness Centre to collect my personal data, and I authorize the acting chiropodist to treat myself.

I also authorize my personal information to be released to my family physician.

_____ _____

Signature of patient/guardian Date

_____ _____

Signature of witness Date