Collective Foot & Wellness Clinic
1423 Upper Ottawa Street, Unit 4&5
Hamilton, Ontario L8W 3J6
905-527-4817

PATIENT INTAKE FORM

First name: _____ Last name: _____

Preferred name: _____ Preferred pronouns: □ She/Her □ He/Him □ They/Them Other: _____

Address: _____City: _____ Postal code: _____

Phone: (H) _____ (C) _____

Date of birth: (D/M/Y) _____ Occupation: _____

How would you like appointments confirmed? □ Email address: _____ □ SMS/Text

Emergency contact: First name: _____ Last name _____

Relationship: _____ Phone: _____

How did you hear about our clinic?

□ Newspaper □ Internet □ Doctor □ Other (please specify) _____ □ Friend / family _____

Help us help you!
Please answer the following foot-related questions:

Your foot problems involve:
□ Left foot only □ Right foot only □ Both feet

Why are you here today? Explain your current foot problem:

_____

_____

Is this problem getting:
□ Worse □ Better □ Same / no change

Have you ever had treatment for this problem?
□ Yes □ No

Have you had foot x-rays?: □ Yes □ No
When: _____

What is your current:
Height: _____ Weight: _____ Shoe size: _____

Have you ever been treated for: (systemic conditions)
□ Diabetes - How long have you had it?:_____
□ Heart disease □ Liver disease
□ High blood pressure □ Skin disorder
□ HIV/Aids □ Arthritis
□ Cancer □ Shortness of breath
□ Stroke □ High cholesterol
□ Depression □ Stomach / bowel issues
□ None apply □ Other: _____

On average, how often are you on your feet daily?

_____

What type of shoes do you wear most?
Work: _____ Leisure: _____

Do you wear custom orthotics? □ Yes □ No

What activities do you participate in regularly?
□ Walking How long do you walk? _____
□ Running How far do you run? _____
□ Other: _____

How often do you participate in these activities?

_____

Do you have mobility concerns?
Explain:_____

Have you ever been treated for:
□ Warts □ Calluses □ Gout
□ Broken Foot □ Corns □ Neuroma
□ Bunions □ Flat Feet □ Ingrown Nails
□ Hammer toes □ Ankle Injury □ Ulcerations
□ Heel pain □ High blood pressure
□ Childhood foot problems □ Broken Leg

Do you have any known allergies to:
□ Anesthetics □ Tape/Band-Aids □ Shellfish □ No Allergies
□ Other: _____

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Patient physicians & medical specialists:

Physician Name: _____

Phone #:_____

Has your doctor treated your foot condition? □ Yes □ No

Did this doctor refer you to us? □ Yes □ No

Other doctor: _____Phone: _____

Please list your Rx Medications:

_____

_____

_____

_____

_____

Social history:

Do you smoke? □ Yes □ No If yes, how much? _____

Do you use alcohol? □ Yes □ No If yes, how much?_____

Are you pregnant? □ Yes □ No If yes, when is your due date? _____

Do you take blood thinners? □ Yes □ No If yes, when was your last INR? _____ What was the value?____

Have you had previous surgeries? □ Yes □ No If yes, please explain: _____

Have you ever fainted? □ Yes □ No If yes, please explain: _____

Patient's Consent: (must be completed and signed before foot exam)

□ I consent / allow examination and treatment by the Chiropodist and allow photographs of treatment areas to be taken for the purposes of monitoring my foot conditions.

□ I consent / allow photographs of my foot condition to be used anonymously for educational purposes.

□ I consent / allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information.

□ I consent / allow the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.

□ I understand that Chiropody is not an OHIP-covered service, and I am financially responsible for all charges, whether covered by my health insurance plan or not.

□ I understand that Collective Foot & Wellness Clinic does not offer direct billing to my insurance and I am financially responsible for these charges, as well as, any contact with my insurance company regarding coverage.

□ I understand that service fees are payable at the time service is provided.

□ I consent / allow Collective Foot & Wellness Clinic to contact me through email to confirm appointments or to provide clinical updates.

Patient's name (please print): _____

Patient's signature (or guardian): _____ Date: _____

Collective Foot & Wellness Clinic promises to treat your personal information with respect. Our privacy protocols comply with provincial privacy legislation, the standards of the College of Chiropodists of Ontario, and the law. We will help you, to the best of our ability, investigate any potential coverage for our services but ultimately, it is the patient's responsibility to be aware of their own insurance plan. Be assured that everyone in our office is committed to ensuring that you receive the best quality footcare.

Chiropodist's signature: _____ Date:_____

□ Benjamin Wilkinson B.Sc.Pod (Hons)

□ Sahil Emrith, D. Ch