Norfolk Foot Care New Patient Intake Form

Welcome to Norfolk Foot Care and Orthotics. We strive to provide the best possible foot care for all patients.
Please fill out this form so we can get to know you!

Name: ________________________________ **Date of Birth: (dd/mm/yyyy)** ____________________

Address: ____________________________________ **City:** ___________________________

Postal Code: ____________________ **Email:** ______________________________________

Phone (home): ______________________ **Cell:** _________________________

Preferred Contact Method: **Home Phone** **Cell** **Email** **Other:**____________

Family Physician: ________________________ **Phone:** ___________________________

Emergency Contact Person:____________________ **Phone:**__________________
Relationship:__________________

How did you hear about Norfolk Foot Care:____

MEDICAL HISTORY: (Check all that apply)

	Diabetes Type 1		Gout	List of Medications/Vitamins
	Diabetes Type 2		Cancer	
	Heart Conditions		Cognitive Impairment	
	High Blood Pressure		Multiple Sclerosis	
	Cholesterol		Arthritis	
	Thyroid Conditions		Skin Conditions	
	Lung Disease		Hepatitis A/B/C	
	Kidney Disease		HIV/AIDS	
	Liver Disease		Other:	
	Stroke		Other:	

ALLERGIES

Medications:____________________ **Environmental:**_________________________
Adhesives or Bandaids:______________ **No Known Allergies:**

Do you smoke cigarettes: **YES** **NO** **How many per day:**____________
Surgeries/Fractures:____

Are you slow to heal: **YES** **NO**
HEIGHT: **WEIGHT:** **SHOE SIZE:**

What Brings You In Today: ____________________

How long have you had this problem: ____________________

Have you had any treatment for this problem: ____________________

What is your current level of pain: 1(Low) 2 3 4 5(High)

Physical Activity Level: LOW MEDIUM HIGH **Do you wear custom orthotics:** YES NO

CONSENTS: **Please read and initial beside each box**

	I certify the above information is correct to my knowledge
	I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and associated health professions to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand my personal and medical information is confidential and will only be disclosed to third parties with my permission
	Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24hrs notice for any cancellations or changes to your appointment. Patients who provide less than 24hrs notice, or miss their appointment may be subjected to a $40.00 cancellation fee
	I consent to photographs or videos of treatment areas taken for monitoring or documentation
	I consent to treatment by the Chiropodist
	I understand that I am financially responsible for all charges associated with my care and treatment. I agree to pay in full for all services provided to me at the time of service unless other financial arrangements have been made in advance. I acknowledge that any outstanding balances are my responsibility

Patient's Name (print): ____________________ **Patient's Signature:** ____________________

Guardian's Name(print): ____________________ **Guardian's Signature:** ____________________

Date: ____________________