Foot Clinic Intake Form

Date:_____

Name_____

Date of Birth:_____

Telephone_____ Email_____Preferred method of contact Phone/Email

How did you hear of our services_____

Family Physician/Practitioner_____

Chief Concern today:

_____

_____

Treatments attempted.

Goals of Appointment today:

_____

History of Custom Foot Orthotics YES/NO Date: _____

Surgery to lower limbs_____

Fractures to lower limbs_____

History of wounds/ulcers_____

History of Diabetes_____ Date of Diagnosis____ History of Amputation:

Hypertension (high blood Pressure): YES/NO

Hypotension (low blood pressure): YES/NO

Have you had re-vascularization by a vascular surgeon: _____ Date:_____

Other Medical Conditions not listed above: _____

Medication/Supplements Taken:

_____

_____

Allergies and reactions:_____

Consent to treatment: Yes/No

Signature: _____ Date :_____