Patient Intake Form – Nursing Foot Care Services

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email: _____
- Emergency Contact Name: _____
- Emergency Contact Phone: _____

Medical History:
(Please check all that apply)

☐ Diabetes
☐ Heart Conditions
☐ Circulatory Issues
☐ Skin Conditions (e.g., athlete's foot, eczema)
☐ Neuropathy
☐ Allergies

ALLERGIES: Are you allergic to any of the following?

☐ Gloves ☐ Moisturizer ☐ Adhesive ☐ Alcohol ☐ Wool ☐ Cotton
☐ Other: _____
☐ Medications/Supplements:
_____
☐ Other Health Concerns:
_____

Current Foot Concerns:

☐ Ingrown Nails
☐ Corns/Calluses
☐ Fungal Infections
☐ Pain or Discomfort
☐ Other (please describe): _____

Previous Foot Care Treatments:

☐ Podiatrist Visit
☐ Previous Nursing Foot Care Treatment
☐ Surgery
☐ Other: _____

Consent for Nursing Foot Care Services

I understand that the nursing foot care services provided are intended to maintain foot health and prevent complications. These services may include nail trimming, skin care, wound care and other necessary procedures.

I acknowledge the following:

1. The treatment is for non-invasive foot care.
2. The nurse may provide recommendations but does not diagnose medical conditions.
3. There are risks associated with foot care services, such as minor bleeding or discomfort.
4. I am responsible for informing the nurse of all medical conditions, allergies and concerns.
5. I have the right to refuse or discontinue treatment at any time.

By signing below, I consent to receive nursing foot care services as described above.

Patient Signature: _____ Date: _____

Provider Name: _____

Provider Signature: _____ Date: _____