Patient Intake Form

Medical Footcare

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DATE _____

NAME: _____ DATE OF BIRTH: _____

COVID-19

Are you currently experiencing (please check all that apply):

☐ FEVER ☐ NEW COUGH ☐ NEW SHORTNESS OF BREATH

CONTACT INFORMATION

ADDRESS: _____ CITY: _____

PROVINCE: _____ POSTAL CODE: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____

HOW WOULD YOU LIKE US TO CONFIRM APPOINTMENTS: ☐ PHONE ☐ HOME ☐ WORK ☐ CELL ☐ TEXT ☐ EMAIL

PERSONAL INFORMATION

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

OCCUPATION: _____

FAMILY DOCTOR: _____ ALLERGIES: _____

MEDICATIONS (MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS, ETC.)

HOW DID YOU HEAR ABOUT US?

☐ DOCTOR REFERRAL ☐ NURSE PRACTITIONER ☐ PEDORTHIST

☐ WORD OF MOUTH ☐ ONLINE ☐ WALK-IN

OTHER (PLEASE SPECIFY): _____

REASON FOR YOUR VISIT

In detail, please describe the area of complaint, duration of symptoms, aggravating factors:

On a scale of 1-10 please indicate the degree of pain you're experiencing (0 = no pain at all, 10 = the worst pain you have ever experienced)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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SOCIAL HISTORY INFORMATION

Do you drink alcoholic beverages? YES ☐ NO ☐

Do you smoke? YES ☐ NO ☐ YEARS: _____ QUANTITY: _____

Do you use recreational drugs? YES ☐ NO ☐ FREQUENCY: _____ QUANTITY: _____

PAST MEDICAL HISTORY

Do you suffer from or have you ever been told that you have the following condition and/or diseases (please check all that apply):

CHEST CONDITIONS:

- ☐ Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heart Rate
- ☐ Angina or Chest Pain
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Pacemaker

MUSCULOSKELETAL CONDITIONS:

- ☐ Neck/Upper Back
- ☐ Lower Back
- ☐ Shoulder
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ Other _____

HEAD/NECK CONDITIONS:

- ☐ Headaches/Migraines
- ☐ Neck Pain/Stiffness
- ☐ Ear Problems
- ☐ Vision Problems

OTHER CONDITIONS:

- ☐ Arthritis
- ☐ Allergies
- ☐ Bowel or Bladder
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Sciatica
- ☐ Thyroid Condition
- ☐ Nausea or Vomiting
- ☐ Pain in Arms or Legs
- ☐ Sensation Loss or Numbness
- ☐ Hemophilia
- ☐ Trouble with Swallowing/Speech
- ☐ Other _____

CIRCULATORY PROBLEMS:

- ☐ Stroke/CVA
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ General Circulatory Problems

INFECTIONS:

- ☐ HIV
- ☐ Tuberculosis
- ☐ Skin Conditions
- ☐ Hepatitis
- ☐ Other _____

SENSITIVITIES TO:

- ☐ Drugs
- ☐ Tape
- ☐ Cold
- ☐ Latex
- ☐ Other

WOMEN:

- ☐ Pregnant

NOTES (CLINIC USE ONLY)

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Patient Privacy & Consent to Assessment

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YOUR PRIVACY

As your privacy is an important part of our clinic protocol, our staff are aware and trained in the appropriate uses and protection of your information in order to ensure confidentiality.

Our clinic collects, uses and discloses personal information for the purpose of providing treatment and services to our patients. BioPed has a corporate commitment, and our BioPed Clinicians (which includes our Pedorthists, Chiropodists, Foot Care Nurses and Physiotherapists) and clinic staff have a professional obligation to keep all personal information, in our possession, confidential and secure.

Information that we may collect includes your name, address, email address, phone number, birth date, height, weight, medical conditions and history, allergies, health insurance and benefit claim information.

We will use and disclose this information only for the following purposes:

- To ensure the accuracy of information on file and to be able to contact you
- To comply with professional, legal and regulatory requirements or as otherwise required by law
- To provide health plan insurers information in order to process your claims and benefits
- To confer with your health care provider or inform them about your treatment plan
- To inform you of additional services offered by BioPed which may be beneficial to you

BioPed will never disclose patient information, except in those circumstances listed above. If you do not wish us to use and disclose this information for the purposes described above, please advise our staff who will make a notation in your file. If this decision on your part limits the clinician from providing you with appropriate treatment, you will be advised accordingly.

PATIENT CONSENT

I have read and understand the contents of this form. I consent to the BioPed Clinician performing an assessment. I further understand that the BioPed Clinician will review treatment recommendations and options with me following the assessment and during future appointments at BioPed Footcare. By signing this consent form, you are confirming that:

- All information in this form is correct to your best knowledge.
- You give your informed consent to the collection, use and disclosure of information for the purposes identified in this form.

EMAIL CONSENT

☐ I provide consent to receive BioPed emails, including offers and promotions, newsletters and company updates. I understand that I can withdraw this consent at any time.

PATIENT SIGNATURE: _____ DATE: _____
OR LEGAL GUARDIAN

PATIENT NAME (PLEASE PRINT): _____
OR LEGAL GUARDIAN

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