Fillier Foot Clinic & ORTHOTICS

2140 Regent Street Unit 14 Sudbury, ON P3E 5S8 Tel: 705-806-1275 Fax: 705-806-1267

Patient Intake Form

Name_____
(First) (Last)

Address_____
(City) (Province) (Postal Code)

Home Number_____ Cell Number_____

Work Number _____Referred By _____

Email_____ Y/N (can email-circle one)

Emergency Contact: _____Phone: _____

Relationship: _____

Date of Birth _____ Gender: Male/Female/Other (Circle one)
(Month/Day/Year)

Height_____ Weight_____(lbs) Shoe size_____

Occupation _____ Footwear _____

Family Doctor/Nurse Practitioner:_____

How did you hear about us?_____

Reason for Visit_____
_____

If you have pain or discomfort please rate it below (circle one)

Mild 1 2 3 4 5 6 7 8 9 10 Severe

Allergies_____

Medical History

Diabetes Mellitus Type I ☐ Type II ☐ How long?_____

Insulin? Y/N Diet/Exercise Y/N

Arthritis: Osteo ☐ Rheumatoid ☐ Other_____

Cardiovascular: High Blood Pressure ☐ Low Blood Pressure ☐

High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Angina ☐

Varicose Veins ☐ Bleeding Disorder ☐ Other_____

Respiratory: Asthma ☐ COPD ☐ Other_____

Neurological: Parkinsons ☐ Multiple Sclerosis ☐ Alzheimer's ☐ Seizures ☐

Neuropathy ☐ Numbness ☐ Charcot Marie Tooth ☐

Psychological: Depression ☐ Anxiety ☐ Other _____

Kidney, Liver, Thyroid _____

Auto Immune Disorder_____

Fractures _____

Surgeries _____

Cancer _____

Dermatological: Eczema ☐ Lichen Planus ☐ Psoriasis ☐

Other_____

Smoker past or present? Y/N Alcohol Y/N Recreational Drugs Y/N

Medication (including vitamins, supplements):_____

_____

Consent to Treatment

I understand the Chiropodist is providing foot assessments and treatments within the scope of practice as defined by the College of Chiropodists of Ontario. I hereby consent to my Chiropodist to treat me within the scope of practice. I allow photographs of my feet to be taken for monitoring and education purposes.

I authorize release of any medical information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, as well as other data pertinent to my treatment, by Kara Fillier, registered chiropodist, to my physician(s) or other health care providers currently involved in my care.

I understand that I am financially responsible for all charges, whether covered by my extended insurance plan or not. I understand that chiropody service fees are payable at the time of the appointment. I acknowledge that custom made/ordered devices are not refundable.

Cancellation Policy

We try to provide exceptional service to our patients. To help us achieve this, we ask that you provide us with at least 24 business hours' notice if you need to reschedule or cancel your appointment, otherwise a 40$ no show fee will apply. Thank you for your consideration.

Signed _____**Date:** _____

(Patient or Guardian) (MM/DD/YYYY)

Print Name: _____

(Patient or Guardian)