Patient Information & Intake Form

Please fill out all three pages to the best of your abilities. Ask for assistance if required.

Patient Information

Last Name:_____ First Name: _____ Middle:_____

Home Address: _____ Apt/Unit #: _____

City: _____ Postal Code: _____

Cell Phone #: _____ Home Phone #: _____

Email Address *(for reminders)*: _____

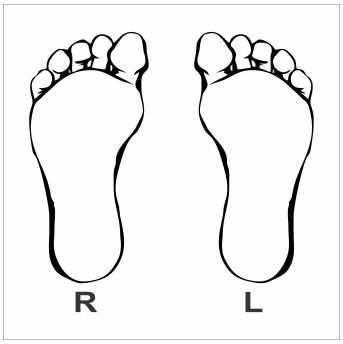
Age: _____ Date of Birth: Year _____ Month _____ Day _____ Sex: M ☐ F ☐ O ☐

Emergency Contact Person: _____ Relation: _____ Phone #: _____

Family Doctor: _____ Location/City: _____ Phone #: _____
(*first & last name)*

How did you hear about us? _____
(*Internet search, advertisement, doctor's referral, family, friend, coworker.* ***Please specify who or which doctor referred etc.***)

Medical Information



Body Part(s) of Concern: _____

Date of Injury/Onset of Symptoms: _____

Describe Injury/Symptoms: _____

_____

Rate Your Pain:(Least) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ (Most)

Past Related Treatments: ☐ Physiotherapy ☐ Shockwave ☐ Therapy ☐ Massage ☐ Injections ☐ Bracing ☐ Surgery

Have you worn custom orthotics (inserts) before? Yes ☐ No ☐ Age of orthotics: ____ Made By: _____

If female: Are you pregnant? Yes ☐ No ☐

Height: _____ Weight: _____ Shoe Size: _____

Insurance Information *(For custom-made orthotics and other prescribed devices only)*

Primary Insurance Company: _____ Secondary Insurance Company: _____

Employer: _____ Employer: _____

Group/Plan #: _____ Group/Plan #: _____

I.D./Certificate #: _____ I.D./Certificate #: _____

WSIB ☐ DVA ☐ Indian Affairs ☐ MVA ☐ ODSP ☐ OW ☐ Claim/Identification #: _____

Other Illnesses or Diseases

☐ None

☐ AIDS/HIV
☐ Anemia
☐ Arthritis _____
☐ Artificial Joint _____
☐ Asthma
☐ Bleeding Disorders
☐ Blood Clots/DVT
☐ Cancer _____
☐ Circulatory _____
☐ Dementia/Alzheimer's
☐ DiabetesI ☐ II ☐ Years _____
☐ Diabetes Last Blood Sugar ___
☐ Emphysema or COPD
☐ Epilepsy
☐ Fibromyalgia
☐ Gout
☐ Headaches
☐ Heart Disease _____
☐ Hepatitis
☐ High Blood Pressure
☐ IBS / Colitis / Crohns
☐ Kidney Problems
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Muscle Disease
☐ Night Cramps
☐ Osteoporosis / Osteopenia
☐ Parkinson's Disease
☐ Psychiatric _____
☐ Raynaud's Disease
☐ Skin Conditions
☐ Stroke
☐ Thyroid Disease
☐ Ulcer _____
☐ Vision Problems

Other: _____

Please list any other medical conditions not listed above that you have been diagnosed with by a physician.

Allergies

☐ None

☐ Adhesives/Tape
☐ Antibiotics _____
☐ Aspirin
☐ Codeine
☐ Cortisone
☐ Ibuprofen/Advil
☐ Iodine/Shellfish
☐ Latex
☐ Local Anesthetics
☐ Metal Sensitivity _____
☐ NSAIDs _____
☐ Pain Medications _____
☐ Sulfa
☐ Tylenol
☐ Other _____

Medications

☐ None

_____

Ask reception for a copy of your list. If you cannot recall which medications you take, please state the condition you take them for.

Previous Relevant Surgeries, Hospitalization & Injuries

☐ None

_____

Family History of Illness *(including foot problems)*

☐ None

_____

Social History

Exercise? ☐ No ☐ Yes Type and Frequency? _____
Tobacco Use? ☐ No ☐ Yes How much per day? _____ How many years: _____ Year Quit: _____
Alcohol Use? ☐ No ☐ Yes How much per week? _____
Drug Use? ☐ No ☐ Yes What type? _____

Consent to Assessment and Treatment

I hereby give consent to undergo an assessment and treatment with the Foot Specialist (Orthopaedic Surgeon/Chiropodist/Certified Pedorthist/Orthotic Technician/Assistant/Nurse) at The Hamilton Foot Clinic/The Foot & Ankle Institute. While under the supervision of the Foot Specialist, my care may involve delegation of some duties and tasks to an assistant. My care may involve telehealth communications (virtual care) via phone, fax, email or mail. During my assessment the Foot Specialist will be asking me questions pertaining to my condition and medical history, and performing a clinical examination that may require 'hands-on' testing. I understand that the Foot Specialist will discuss the assessment findings with me and provide a prognosis for my condition and a predictive outcome. I understand that the Foot Specialist will discuss treatment options with me at the completion of the assessment. I understand that it is important that I give the most accurate health history and information to my Foot Specialist so that any planned treatments and therapies are in my best interest. I am aware that I have the opportunity to ask my Foot Specialist any questions pertaining to my condition and discuss the risks and benefits of my treatment plan and overall care. This location is not an eligible provider for GSC insurance.

Consent to Release Information

I hereby give permission for the Foot Specialist to release/discuss any pertinent medical information obtained with my Physician, Insurance Company, Case Worker, WSIB representative or Lawyer.

Consent to Request Information

I hereby give permission for the Foot Specialist to request on my behalf from a 3rd party the results of any assessment or diagnostic tests (i.e., x-ray, ultrasound, bone scan, MRI, CT scan) related to my injury/condition in order for him/her to make assessment and treatment decisions.

Consent to Ownership of Patient Records

I hereby give consent that all patient records are the property of Hamilton Foot Clinic / Foot and Ankle Institute. I have the right to view my records at any time and can request copies to be made.

Signature of patient: _____ Date: _____

OFFICE USE ONLY

Health History Update

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____

Date of Update: _____ Significant changes?Yes ☐ No ☐

If yes, specify change: _____

Signature: _____