# The Hamilton Foot Clinic

**Patient Intake Form**

## Patient Information

Surname: ________________________________ Given Name: ________________________________

Home Address: ________________________________________ Apt/Unit #: ____________________

City: ________________________________________ Postal Code: ____________________________

Primary Phone #: _______________________ Secondary Phone Number #: _______________________

Email Address: ____________________________________________

Health Card #: _______________________________ Version Code _________ Expiry Date _________

Date of Birth: Day _________ Month _________ Year _________ Sex: M _________ F _________

Family Physician: _______________________________ Location/City __________________________

How did you hear about us? _______________________________________________________________

(*Internet search, advertisement, doctor's referral, family, friend, coworker, please specify who or where etc.*)

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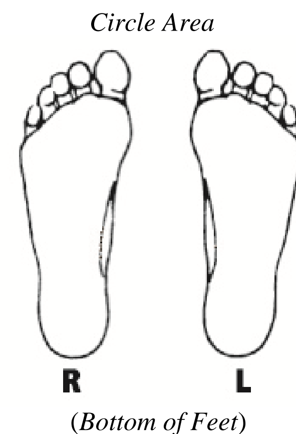
## Medical Information

Body Part(s) of Concern: _______________________________________________________________

*Circle Area*




(*Bottom of Feet*)

Date of Injury/Onset of Symptoms: _________________________________

Describe Injury/Symptoms: ________________________________________

_____________________________________________________________

How do these symptoms affect your life: _____________________________

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

Past Related Treatments: Physiotherapy Massage Orthotics Bracing

History: Past Surgeries Diabetes (Type I/II) Arthritis Other: ________________________________

Allergies: Codeine Cortisone Adhesive Tape Bandages Latex Other: ________________________

Medications: ________________________________________________________________________

Height: ____________________ Weight: ____________________ Shoe Size: ____________________

**Insurance Information**

*Extended Health Insurance*

Primary Insurance Company: ___________________ Secondary Insurance Company: _________________

Employer: ___________________________________ Employer: ___________________________________

Group/Plan #: ________________________________ Group/Plan #: ________________________________

I.D./Certificate #: _____________________________ I.D./Certificate #: _____________________________

Secondary Insurance Spousal Name: ___________________________ Date of Birth: ____________________

*Other Health Insurance and Coverages*

WSIB DVA ODSP OW Indian Affairs MVA

Claim/Identification #: ________________________________________________________________________

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*I understand that the information collected on this form is relevant to the care I will receive from The Hamilton Foot Clinic. I am aware that The Hamilton Foot Clinic has their privacy policy that will be made readily available to me upon request. I agree to The Hamilton Foot Clinic collecting, using and only disclosing my personal information to specific parties as set out in their privacy policy.*

Patient Signature: ___________________________________________ Date: __________________________