**Client Personal Information and Health History**

Date: \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyy

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| **Personal Information** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyy  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_  Home Phone #: (\_\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * May we email you for updates and appointment reminders? Yes No   Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_ Shoe Size: \_\_\_\_\_\_\_\_\_\_\_\_\_  AB Health Care #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Insurer #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Secondary Insurer #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other specialists involved in your foot/wound care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Health History** |
| Today’s main concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous foot care/wound treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you diabetic? Yes No Type I Type II  How many years? \_\_\_\_\_\_\_\_\_ Last A1C: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyy  Do you smoke? Yes No When did you quit? \_\_\_dd \_\_\_\_\_mmm \_\_\_\_\_\_yyyy  Number of years you smoked: \_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you drink alcohol: Yes No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use street drugs? Yes No What type of drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you satisfied with your nutrition/weight? Yes No  If not, what is your desired weight loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have neuropathy or numbness/tingling in your feet? Yes No  Have you ever had a leg or foot circulation test (ABI)? Yes No  Medications/Supplements: Name Dose Reason  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current foot problems (check all that apply):   |  |  |  |  | | --- | --- | --- | --- | | Athlete’s Foot | Claw Toes | Fungus | Plantar Fasciitis | | Blisters | Corns | Gout | Sweaty Feet | | Bunions | Dry skin | Hammer Toes | Thickened Nails | | Calluses | Fissures | High Arch | Ulcers | | Cellulitis | Flat Feet | Ingrown Toenails | Warts | | Charcot Foot | Fractures | Mallet Toes | Yellow Nails |   Other Health Concerns: *(Please list all health conditions you are currently being treated for or are a concern to you at this time)*  **Allergies** *(list all medications, food, adhesives, latex, cleansers, lotions, other)* |