**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 \_\_\_\_\_\_yyyyAddress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 \_\_\_\_\_\_yyyyDo 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):

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| 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)* |