MCCOWAN FOOT CLINIC

Feel Good On Your Feet. Stay Healthy.

PATIENT INTAKE FORM

How did you hear about McCowan Foot Clinic?

☐ Internet ☐ Physician ☐ Friend ☐ Co-worker ☐ Other: Specify: _____
☐ Family ☐ Sign ☐ Walk-in ☐ Newspaper

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr. Date: _____

First Name: _____ Last Name: _____

Date of Birth (DD/MM/YYYY): _____ E-mail: _____

Address: Street _____ Apt. # _____

City: _____ Postal Code: _____

Occupation: _____ Place of Employment: _____

Home Phone #: _____ Cell Phone#: _____ Business Phone #:_____

Family Doctor Name: _____ Family Doctor Phone # _____

Family Doctor Address: _____

Referring Doctor: _____

REASON FOR VISIT

What is your main foot complaint? Explain in detail. _____

_____

Have you seen a Chiropodist/Podiatrist before? ☐ Yes ☐ No

If yes, for what condition? _____ When? _____

Type of shoes worn daily _____

ALLERGIES (specify) _____

CURRENT COMPLAINT (Please check)

☐ Assessment/General Check-up
☐ Corns
☐ Calluses
☐ Warts
☐ Fungal Toenails
☐ Thick Toenails
☐ Diabetic Footcare
☐ Foot Odour
☐ Ulcer
☐ Ingrown Toenail
☐ Ingrown Toenail Surgery
☐ Laser for Fungal Nails
☐ Laser for Warts
☐ Athlete's Foot
☐ Heel Pain
☐ Painful Feet
☐ Flatfeet
☐ High Arched Foot
☐ Pain in the ball of the foot
☐ Achilles Pain
☐ Bunions
☐ Arch Pain
☐ Swelling in the ankles
☐ Varicose Veins
☐ Orthotics
☐ Orthopaedic Shoes
☐ Custom-made Shoes
☐ Compression Stockings
☐ Ankle Foot Orthoses
☐ Lower Back Pain
☐ Hammer Toes

AGGRAVATED BY

☐ Walking ☐ Physical Activity ☐ After Rest
☐ Standing ☐ In the morning

Please Check

☐ **Good General Health**

ENDORCRINE
☐ Diabetes (type 1) for # of yrs: _____
☐ Diabetes (type 2) for # of yrs: _____
☐ Thyroidism
☐ Osteoporosis

MUSCULOSKELETAL
☐ Back Conditions
☐ Gout
☐ Osteopenia
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Fracture. Where? _____
☐ Neuromuscular disorder _____
_____
☐ Psychological _____
_____
_____

DERMATOLOGICAL
☐ Psoriasis
☐ Eczema
☐ Fungal
☐ Other: _____
_____

RESPIRATORY
☐ Asthma
☐ Bronchitis
☐ COPD

CARDIAC
☐ Hypertension (High Blood Pressure)
☐ High Cholesterol
☐ Congestive Heart Failure
☐ Poor Circulation
☐ Varicose Veins
☐ Angina
☐ Myocardial Infarction (Heart Attack)
☐ Other: _____
_____

BRAIN & NERVOUS SYSTEM DISORDER
☐ Stroke
☐ Epilepsy
☐ Other: _____

OTHER MEDICAL CONDITIONS
_____
_____
_____
_____

MEDICATIONS	FOR	PAST SURGERIES	YEAR

FEES ARE NOT COVERED BY OHIP

PLAN MEMBER INFORMATION
Name of Insurance Company:
_____
Plan #: _____ I.D. # _____
Policy #: _____Contract #: _____
Plan Member's Name: _____
Company's Name: _____

CO-ORDINATION OF BENEFIT
Name of Insurance Company:
_____
Plan #: _____ I.D. # _____
Policy #: _____Contract #: _____
Plan Member's Name: _____
Company's Name: _____

PATIENT'S CONSENT

I give my consent to examination and treatment by the Chiropodist.
I give my consent to the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.
I understand that I am financially responsible for all charges whether covered by my health insurance plan or not.
I understand that service fees are payable at the time service is provided.
Our privacy policy at McCowan Foot Clinic is in compliance with the privacy protocols and standards set by the College of Chiropodists of Ontario.

Patient's Signature: _____ Date: _____

Signature of Witness: _____

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