



**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)

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

**AGGRAVATED BY**

- Walking       Physical Activity       After Rest

**Please Check**

Standing  
 In

the morning

**Good General Health**

**MUSCULOSKELETAL**

**ENDORCRINE**

- Diabetes (type 1) for # of yrs: \_\_\_\_\_
- Diabetes (type 2) for # of yrs: \_\_\_\_\_
- Thyroidism
- Osteoporosis

- Back Conditions \_\_\_\_\_
- Gout \_\_\_\_\_
- Osteopenia \_\_\_\_\_
- Osteoarthritis \_\_\_\_\_
- Rheumatoid Arthritis \_\_\_\_\_
- Fracture. Where? \_\_\_\_\_
- Neuromuscular disorder \_\_\_\_\_
- Psychological \_\_\_\_\_

**DERMATOLOGICAL**

- Psoriasis
- Eczema
- Fungal
- Other: \_\_\_\_\_

**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: \_\_\_\_\_

**RESPIRATORY**

- Asthma
- Bronchitis
- COPD

**OTHER MEDICAL CONDITIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FEES ARE NOT COVERED BY OHIP**

MEDICATIONS	FOR	PAST SURGERIES	YEAR

**PLAN MEMBER INFORMATION**

Name of Insurance Company: \_\_\_\_\_

**CO-ORDINATION OF BENEFIT**

Name of Insurance Company: \_\_\_\_\_

Plan #: \_\_\_\_\_ I.D. # \_\_\_\_\_  
Policy #: \_\_\_\_\_ Contract #: \_\_\_\_\_  
Plan Member's Name: \_\_\_\_\_  
Company's Name: \_\_\_\_\_

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 Chiroprapist.

I give my consent to the Chiroprapist to send my physician or health care professional a report regarding my foot exam and treatment plan if necessary.

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 Chiroprapists of Ontario.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_