Ottawa **Foot** Clinic Intake Form

Please note it is necessary to complete **both sides** of the following questionnaire.

All information will remain confidential.

Name:		C	Date of Birth:/	//					
F	First	Last	D	M Y					
Address:									
Street		City	Province	Postal Code					
Home Phone or Ce	ll #: Work #: _	E-mail	nail:						
Person responsible	for account (if different): _		Phone #:						
Emergency Contact	mergency Contact: Phone #:								
	ULTATION								
HOW LONG HAS TH	IE ISSUE/PAIN BEEN PRESENT	т:							
	IVED TO DATE:								
		DICAL HISTORY							
How would you des	scribe your general health?	□Excellent □Goo	od □Average □Poo	or					
Do you currently su	uffer from, or are you being t	reated for any of the	e following health cond	litions?					
☐ Diabetes	□Neurological Problems	□Ostearthritis	☐High Blood Press	ure					
☐ High Cholesterol	☐Kidney Problems	□Cardiac Problem	s □Hormonal Proble	ms					
□Arthritis	□Osteoporosis	☐ Skin Problems	□Gout: last attack						
□Hepatitis	☐ Poor Circulation	☐ Phlebitis	□Asthma						

MEDICAL HISTORY (Cont'd)

Have you tested HIV <u>positive</u> : □Yes	□No	☐ Have nev	er been tes	ted		
Have you ever received general anesthe	esia? □					
Have you ever received local anesthesia	? □					
Have you ever had a sprained ankle or a						
Do you presently take any prescription in Please list here or provide a separate type	medications? [ped list:	⊒Yes				
Do you take any natural remedies or sup						
Do you suffer from any serious allergies a separate typed list:	(antibiotics, la	atex, creams, a	nesthetics)	? Please	specify	y or provide
How did you hear about the Ottawa Foo						
I have reviewed the information in this of a understand that this information will be assessment and treatment options. If the chiropodist. I acknowledge that fees for appointment. I further understand that and that missed appointments or short in	e used by the ere is any chai services are n 24 hours' notic	chiropodist to nge in my med ot covered by (ce is required t	help detern ical status, OHIP and a o reschedu	nine app I will inf re payab le or can	ropriation the least end of the least en	te e ach pointments,
Signature:		Date:	/ .		_ / _	
Patient / Parent /	Guardian		D	M		Υ

Ottawa Foot Clinic

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