Foot by Foot

Client #______________________

Thank you for selecting Foot by Foot .
In order to serve you properly, PLEASE PRINT all of the following information.

Name:______________________ Home Phone:______________________

Address:______________________ Cell Phone:______________________

City:__________ Postal Code:__________ Email:______________________

D.O.B: Yr ________ M ________ D ________ Occupation:______________________

Height______ Weight______ Sex: M ☐ F ☐ Employer:______________________

Family Physician:______________________ Insurance Plan 1______________________

Referring Physician:______________________ 2______________________

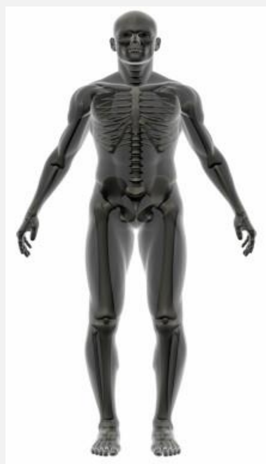
How did you hear about

☐ Friend/family/colleague ______________________

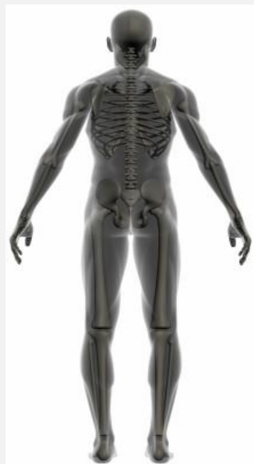
☐ Health care professional ______________________

☐ Website ☐ Internet Search ☐ Yellow Pages ☐ Repeat Client

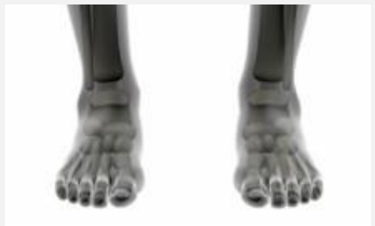
☐ Brochure ☐ Newspaper ☐ Other______________________

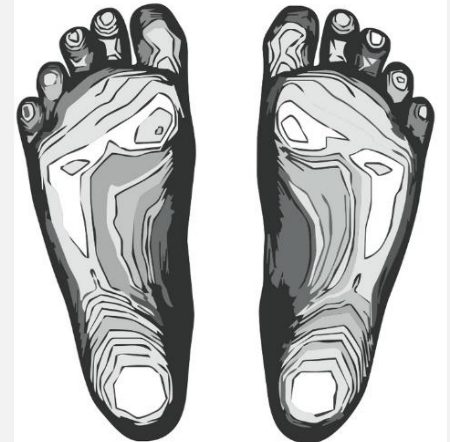


Front



Back





Right Left

○ Circle your painful areas ③ Inside the circle rate your pain - 1 Mild 3 Moderate 5 Severe

Does the pain LIMIT your activities? ☐ Yes ☐ No

WHEN do you experience the pain? ☐ Morning ☐ Activity ☐ Rest ☐ Weight Bearing ☐ Night time

How LONG have you experiened the pain? ______________________

Continued -->

Currently are you getting any TREATMENT for your pain? ____

Do you have a history of SURGERY or broken bones or injury to your back, legs or feet?______________________________

On average how much TIME are you on your feet? ☐ **20%** ☐ **40%** ☐ **60%** ☐ **80%** ☐ **100%**

Type of SHOES worn at: Work________________ Home ______________ Casual_________________Sports________________

Shoe size ____________________________ Width ____

Do you currently wear Orthotics? (Shoe Inserts) ☐ **Yes** ☐ **No How old are they?_______________________________**

What sport or activities do you participate in?____

Have your ever been DIAGNOSED with?

☐ **Osteo Arthritis** ☐ **Diabetes** ☐ **Stroke** ☐ **Leg length difference** ☐ **Charcot Marie Tooth**

☐ **Fibromyalgia** ☐ **Circulation Issues** ☐ **Nerve Damage** ☐ **Rheumatoid Arthritis** **Other___________________**

Is there anything else we should know about your health?____

At Foot by Foot, we understand the importance of protecting your personal information and we follow the guidelines of the Personal Information Protection and Electronic Documents Act. Personal information gathered on this intake form and your on-going file are collected to help us assess your health , plan your course of treatment and to advise you of your options and provide the care you choose to have.

Patient Consent

I give consent to being treated as a patient of Foot by Foot.
I consent/allow Foot by Foot to send my physician and/or health care professional within my circle of care a report relating to my foot examination.

(Your typed name acts as a signature to the above)

Patient/Guardian Signature: ____ Date: ____________________

***********TO BE COMPLETED AFTER ASSESSMENT************

I understand that I am financially responsible for all charges whether covered by my health insurance plan or not.

I understand payment in full is due upon receiving my orthotics and/or shoes. (In some cases a deposit is required)

Custom Made Orthotics $_______________ Deposit $______________

Footwear $_______________

Modifications $_______________

Patient/Guardian Signature: ____ Date: ____________________

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Is there anything else you would like to tell us about your back, leg, knee or back pain?

Notes