Foot by Foot

Client #_____

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

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City:_____ PC:_____ Email:_____

D.O.B: Yr _____ M _____D _____ Occupation:_____

Height_____ Weight_____ Sex: M ☐ F ☐ Employer:_____

Family Physician:_____ Insurance Plan 1_____

Referring Physician:_____ 2_____

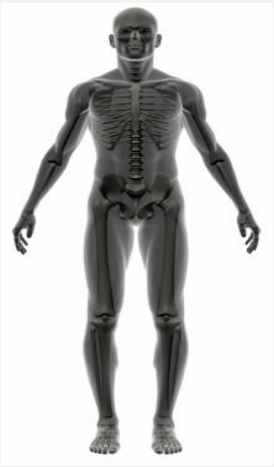
How did you hear about Foot by Foot

☐ Friend/family/colleague _____

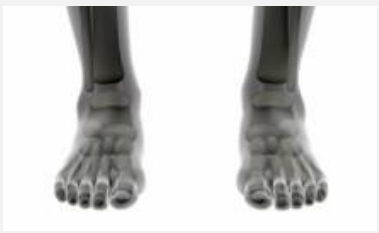
☐ Health care professional _____

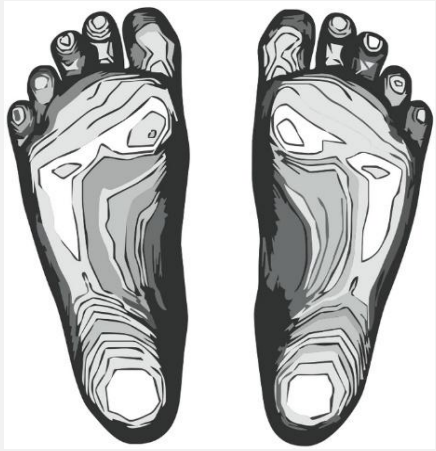
☐ Website ☐ Internet Search ☐ Yellow Pages ☐ Repeat Client

☐ 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 in 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_____

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

Have your ever been DIAGNOSED with?

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

☐ **Fibromyalgia** ☐ **Stroke** ☐ **Nerve Damage** ☐ **Rheumatoid Arthritis** ☐ **Circulatory Conditions**

What sport or activities do you participate in?_____

At Foot by Foot Orthotics 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 Orthotics.**

☐ **I consent/allow Foot by Foot to send my physcian and/or health care professional within my circle of care a report relating to my foot examination.**

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: _____**