Kanata Foot & Orthotics Clinic

Patient Intake Form

Contact Information

First name: _____Last name: _____

Gender: Address:

City:_____Prov: _____ Postal Code: _____

Preferred phone number: (____)_____ ☐ Home, ☐ Mobile, ☐ Work

Secondary phone number: (____)_____ ☐ Home, ☐ Mobile, ☐ Work

Email: _____

Would you like to receive appointment reminders by email? …….. Yes / No

Date of Birth: (DD/MM/YYYY)_____Occupation:_____

Parent/Guardian (if applicable): _____

Referred by: _____How did you hear about us? _____

Insurance information:
If you have personal health insurance, please provide reception with your insurance card/policy number at the time of your appointment. They will make a photocopy to add to your patient file.
**** Please note that we can not direct bill every insurance plan.**

Please list the medications you are taking below. Alternatively, please give us your medication list:

Health History

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

What is your main reason for coming in today?

_____

Family physician: _____ , Tel.:_____

Please check all of the following healthcare practitioners you have seen or are currently seeing:

☐ Physiotherapist ☐ Chiropractor ☐ Massage Therapist ☐ Osteopath ☐ Other: _____

Current Complaint(s)		**Allergies:**
❑ Athlete's Foot ❑ Thick nails ❑ Diabetic Foot Care ❑ Callous ❑ Corn(s)	❑ Wart(s) ❑ Fungal infection ❑ In-grown nail(s) ❑ Painful feet ❑ Orthotics / shoes ❑ Other: _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Medical History		
Cardiovascular: ❑ Stroke ❑ Angina ❑ Heart attack ❑ Hypertension ❑ Clotting disorders ❑ Anemia Respiratory: ❑ Asthma ❑ Bronchitis ❑ Emphysema Psychological: ❑ Anxiety ❑ Depression	Endocrine: ❑ Type 1 Diabetes for ___ yrs ❑ Type 2 Diabetes for ___ yrs ❑ Hypothyroidism ❑ Hyperthyroidism ❑ Kidney disease: _____ ❑ Liver disease: _____ Musculoskeletal: ❑ Osteoarthritis: _____ ❑ Rheumatoid arthritis ❑ Osteoporosis ❑ Gout ❑ Back condition: _____ ❑ Fractures: _____ _____	❑ HIV ❑ Hepatitis: _____ ❑ Cancer: _____ ❑ Stomach ulcer(s) ❑ Other: _____ Hospitalization(s): _____ _____ _____ Do you smoke? ❑ Yes ❑ No ❑ I use to for _____ years Do you drink alcohol? ❑ Yes, _____drinks per week ❑ No

If you suffer from any other medical conditions not listed above, please let us know.

Consent for Chiropody Treatment

CONSENT TO TREATMENT

I understand that the chiropodists are providing foot assessments and treatments within their scope of practice as defined by the College of Chiropodists of Ontario. I hereby consent to my Chiropodist to treat me within the scope of practice. I understand that the chiropodist will explain to me the risks and benefits of the proposed treatment and will answer all my questions prior to any treatment.

As a clinical placement site of The Michener Institute of Education at UHN, both of our chiropodists are clinical educators participating in the clinical training of third year intern chiropodists. You may receive supervised assessment/treatment from an intern per your agreement.

RELEASE OF INFORMATION

I authorize release of any medical information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, as well as other data pertinent to my treatment by my chiropodist to my physician(s) or other healthcare providers currently involved in my care.

PAYMENT AUTHORIZATION

I understand the fee structure and accept full responsibility for prompt payment. I acknowledge that chiropody services are not covered by the Ontario Health Insurance Plan (OHIP).

I assume full financial responsibility for payment of all expenses associated with my treatment, including any charges not covered by insurance, supplies required during my course of treatment and insurance policy deductibles. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself and, therefore, it is my responsibility to understand the requirements and limitations of my insurance coverage. I will immediately notify my chiropodist of any changes in my insurance coverage during my course of treatment.

CANCELLATION/NO-SHOW POLICY

I will provide at least 24-hours' notice prior to canceling or rescheduling an appointment. I understand that there may be a fee equivalent to the scheduled service for no-shows and late cancellations. For policy details, please visit https://www.kanatafootclinic.ca/index.php/table/policy/ to review our Cancellation, No-Show and Lateness Policy.

_____

Patient's Name

_____ _____

Signature of Patient/Guardian (if under 18 years of age) DATE (DD/MM/YYYY)

COVID-19 SCREENING

1) ☐ Yes ☐ No Have you been in close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days?

2) ☐ Yes ☐ No Do you have a confirmed case of Covid 19 or have you been in close contact with someone who has been confirmed (tested positive) with COVID-19 in the past 14 days?

3) ☐ Yes ☐ No Do you have <u>any</u> of the following symptoms:

- **Fever**
- **New onset of cough**
- **Worsening chronic cough**
- **Shortness of breath**
- **Difficulty breathing**
- **Sore throat**
- **Difficulty swallowing**
- **Decrease or loss of sense taste or smell**
- **Chills**
- **Headaches**
- **Unexplained fatigue/malaise/muscle aches**
- **Nausea/vomiting/ Diarrhea**
- **Abdominal pain**
- **Pink eye (conjunctivitis)**
- **Runny nose/Nasal congestion – in absence of underlying reasons for the symptoms such as seasonal allergies, post-nasal drip, etc.**

4) ☐ Yes ☐ No If you are 70 years of age or older, are you experiencing <u>any</u> of the following symptoms: delirium (confusion), unexplained or increased number of falls, acute functional decline (loss of mobility), or worsening of chronic conditions

RESULT: If you screen positive by answering yes to any of the questions, sanitize your hands, don a mask and let our receptionist know immediately. If you don't have a mask, simply ask our receptionist and she will provide you with one.

IMPORTANT NOTE: The following signs or symptoms require immediate action

- severe difficulty breathing
  (struggling for each breath, can only speak in single words)
- severe chest pain
  (constant tightness or crushing sensation)
- feeling confused
  (for example, unsure of where you are)
- losing consciousness

Print name:_____

Signature: _____