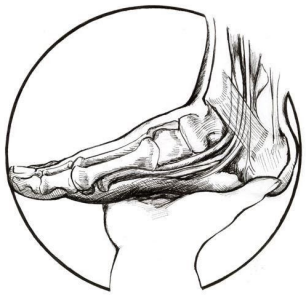

BRADFORD FAMILY ORTHOTIC AND FOOT CLINIC

INTAKE FORM

Chiropodists:
Stephen Chu R.Kin. D.Ch.
Jennifer Chua B.Sc. (Hons), M.Sc, D.Ch.
239 Holland Street West Phone Number: (905) 392-7793
Bradford, ON L3Z 1H9 Fax Number: 1-888-344-8924

*Must be filled out by the patient**

TODAY'S DATE: (MM/DD/YYYY):_____ / _____ /_____

PATIENT NAME:_____

DATE OF BIRTH (DD/MM/YEAR) **GENDER:** □ **MALE** □ **FEMALE** **MARITAL STATUS**: □ **SINGLE** □ **MARRIED**
____ / _____/ _____

ADDRESS:_____

CITY:_____ **POSTAL CODE:** _____

HOME PHONE: (____) - _____ - _____ CELL: (____) - _____ - _____

E-MAIL (for contact purposes only) _____

FAMILY PHYSICIAN'S NAME: _____

FAMILIY PHYSICIAN'S MAJOR INTERSECTION: _____ **&** _____

EMERGENCY CONTACT: _____

Are you employed?: NO: ☐ **YES** ☐ **(Describe Duties)** _____

Do you have private/workplace health insurance? NO☐ **YES** ☐
Name of insurance Company_____

Policy #_____ **ID #** _____

Your Spouse's Plan:

Name of insurance Company_____

Policy #_____ **ID #** _____

How did you hear about us?

Newspaper ☐ **Internet** ☐ **Referral** ☐ **Sign** ☐ **Other** ☐ _____

Previous Relevant surgeries: _____

Allergies: _____

Weight:_____ **Height:** _____ **Shoe Size:** _____

Do you smoke? NO ☐ YES ☐(how much ___/day)

Do you consume alcohol? NO ☐ Occasionally ☐ Weekly ☐ (___/week)

How active are you? Inactive ☐ Occasionally ☐ 3X or more ☐

MEDICATION LIST:

_____ _____ _____

_____ _____ _____

What brings you to our clinic today: _____

Previous Attempted Treatments?

Surgery ☐ Orthotics ☐ Medication ☐ Physiotherapy☐ Other_____

MEDICAL HISTORY

Eyes/Ears	**Respiratory**	**Cardiovascular**
□ Glaucoma □ Cataracts □ Severe hearing □ Vision Impairment □ Other_____	□ Asthma □ Emphysema □ Chronic bronchitis □ Other _____	□ Heart attack □ Congestive heart failure □ High blood pressure □ Varicose veins □ Blood clots □ Stroke □ Other _____
Digestive/Excretory	**Endocrine**	**Musculoskeletal**
□ Kidney problems □ Gallbladder □ Stomach ulcers □ Liver disease □ Other _____	□ Type I/II Diabetes □ Thyroid (Over/Underactive) □ Other _____	□ Osteoporosis □ Osteoarthritis □ Rheumatoid arthritis □ Other _____
Neurological	**Dermatological**	**Communicable Diseases**
□ Neuropathy □ Spinal/head trauma □ Cerebral Palsy □ Parkinson's disease □ Alzheimer's disease □ Other: _____	□ Psoriasis □ Eczema □ Athlete's foot □ Warts □ Other _____	□ HIV/AIDs □ Hepatitis A, B, C □ Other _____

SIGNATURE: ____ **DATE**: ____________________________