

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  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

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 experienced the pain? _____

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 _____ Sports _____

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

Have you 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, 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.

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: _____

