



339 Wellington Rd. South, Unit #135  
 London, Ontario N6C 5Z9  
 Tracy Kyle D.Ch. Chiropracist- Foot Specialist

## Confidential Patient Intake Form

*This information requested below must be completed accurately and in full.*

Name:		Today's Date:	
Address:		City:	Postal Code:
Home Phone:	Cell Phone:	Email:	
Date of Birth:	Age:	Gender:	
Occupation:		Employer:	
Medical Doctor:		Doctor's Phone Number:	
Height:	Weight:	Shoe Size:	
Previous Foot Care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and why?  			
Parent/Guardian Names (if patient is under 18 years of age): Parent: _____ Parent: _____			

<b>Insurance Information:</b>
Primary Insurance Company: _____ Phone: _____ _____
Insured Member's Name: _____
Policy Number: _____ Policy ID: _____ _____
Insured Member's Date of Birth: _____

In Case of Emergency:	
Who should be notified? _____ Relationship: _____	
Phone: _____	
Current Foot Problems:	
Reason for Visit/Current Foot Problems:	
When did this start?	Is the problem getting <input type="checkbox"/> Better? <input type="checkbox"/> Worse? <input type="checkbox"/> The same?
Mark area(s) of pain or issues on the diagrams:	
 <b>Right Foot</b>	 <b>Left Foot</b>
When is this problem most bothersome?	
Describe all attempted treatment for this problem:	
Have you had x-rays done for this treatment?	
Are there any other painful areas on your ankles, knees, legs, thighs, hips or back? Please describe:	

Medical History:			
<p>Please check everything you have been treated for:</p> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hepatitis <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tinnitus <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vertigo <input type="checkbox"/> Anemia <input type="checkbox"/> Cholesterol <input type="checkbox"/> Heart Problems <input type="checkbox"/> Neuropathy <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Bone Disease	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Stroke <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Problems <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Stomach/Bowel <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Ankle Injury <input type="checkbox"/> Hammertoes <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Broken Foot/Leg <input type="checkbox"/> High Arched Feet	<input type="checkbox"/> Bruise easily <input type="checkbox"/> Corns <input type="checkbox"/> Callus <input type="checkbox"/> Ingrown toenail <input type="checkbox"/> Gout <input type="checkbox"/> Arch pain <input type="checkbox"/> Heel pain <input type="checkbox"/> Flat Feet <input type="checkbox"/> Bunions <input type="checkbox"/> Bunionettes <input type="checkbox"/> Warts <input type="checkbox"/> Neuroma <input type="checkbox"/> Knee pain <input type="checkbox"/> Dry & cracking skin <input type="checkbox"/> Eczema/Psoriasis <input type="checkbox"/> Fungus <input type="checkbox"/> Discoloured nails <input type="checkbox"/> Bone Fracture <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Slap Foot/Drop Foot  Other medical conditions not listed:    Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please list your current medications:   			
Are you allergic to any of the following? <input type="checkbox"/> Local Anesthetics (Xylocaine, Novocain, etc.) <input type="checkbox"/> Adhesive Tapes/Band Aids? <input type="checkbox"/> Latex  Are you slow to heal after any cuts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
May we send a report of your foot exam to your Family Physician and/or referring Doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			



### Office Policies & Consent:

#### **FEES:**

All fees for any type of service are required at the time that services are rendered. After a year of not being seen, you will be considered a new patient. A new patient form will need to be filled out as well as full fees will apply as a new assessment will need to be done. If it has been 6 months since your last appointment, there may be a fee increase.

#### **MISSED APPOINTMENTS/LATE FEE:**

Reminder calls/emails are a courtesy provided by the clinic. However, remembering your appointment is your responsibility.

We require two full business days notice for any cancellations.

Failure to give two business days notice for cancellations, failure to show up or any late arrivals will result in a full appointment fee that will need to be paid prior to rebooking.

#### **EXTENDED HEALTHCARE COVERAGE:**

Chiropractic services are not covered under OHIP. While certain extended healthcare companies allow us to direct bill for appointments only, it is your responsibility to check your coverage.

#### **ORTHOTICS:**

Custom made orthotics are \$500. We require a \$250 deposit at the time of casting. All paperwork for insurance is given at the time of the fitting. There is no guarantee and no returns.

After one year, a new cast must be taken.

#### **RETURNS:**

There are no returns on items such as socks, compressions stockings and footwear.

I hereby give consent for the assessment and any treatment by the Chiropractor.

I acknowledge that your office has a Privacy Code and that I can see this code at any time.

I agree that Kyle Foot & Orthotics Clinic can collect, use and disclose personal information about me as set out in their office's privacy policy.

I have read the above consent and have had opportunity to ask questions about its content.

**I have read and acknowledged that the above information is correct. I understand that this information is confidential.**

**I have completed this intake honestly and accurately and understand importance of informing my Chiropractor of any changes.**

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_