



**Personal Information**

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Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Last MM/DD/YYYY

Mailing Address \_\_\_\_\_  
Street Apt. P.O. Box City Postal Code

Phone \_\_\_\_\_  
(Indicate preferred method of contact)  Home  Cell  Work

Email \_\_\_\_\_ Occupation \_\_\_\_\_  
 I provide consent to receive emails

Marital Status \_\_\_\_\_ Company Name \_\_\_\_\_

Primary Language \_\_\_\_\_ Gender  M  F

Shoe Size \_\_\_\_\_ Weight (lbs) \_\_\_\_\_  
Are you covered by any of the following insurances?  WSIB  ODSP  NHIB  
 Veterans Affairs (Blue Cross)

**About Your Visit**

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1. How did you hear about us?  
Check all that apply  
 Website  Billboard  
 Facebook  Spa (Name) \_\_\_\_\_  
 Yellow Pages  Doctor Referral (Name) \_\_\_\_\_  
 Radio Ad  Friend or Family (Who should we thank?) \_\_\_\_\_  
 Signs  Other (Specify) \_\_\_\_\_  
 Flyer

2. Do you have a family doctor?  No  Yes  
Physician's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street Apt. P.O. Box City Postal Code

Do you consent to our clinic sending a report to your family doctor if required?  No  Yes

3. Have you had previous Chiropractic/foot care?  No  Yes  
If yes, where? \_\_\_\_\_

4. What is the reason for your visit today? Onset Date \_\_\_\_\_

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Nail Care             | <input type="checkbox"/> Orthopedic/Custom Shoes  | <input type="checkbox"/> Assessment         | <input type="checkbox"/> Foot Pain          |
| <input type="checkbox"/> Corn/Callus           | <input type="checkbox"/> Custom Orthotics/Insoles | <input type="checkbox"/> Knee/Hip/Back Pain | <input type="checkbox"/> Wart               |
| <input type="checkbox"/> Other (Specify) _____ |   |   | <input type="checkbox"/> Diabetic Foot Care |

5. What are your expectations with today's visit?

\_\_\_\_\_

\_\_\_\_\_

**NOTE:** Privacy of personal information is an important principle to Azilda Family Foot Care. We are committed to collecting, using, and disclosing personal information responsibly, and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. If you have not yet been offered, please ask to review a copy of our Privacy Policy. If required for your case, we will be in contact with your Family Physician.

## Medical Information

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The answers to this medical questionnaire help us identify the cause of your foot problems. All information is confidential.

- |  |  |
|--|--|
| 1. Do you consider yourself to be in good health?    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you consider yourself to be a good healer?     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Do you have any problems with your immune system? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Are you taking any supplements? (Please List)     | <input type="checkbox"/> No <input type="checkbox"/> Yes |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |  |  |
|--|--|
| 5. Are you taking any prescribed medication? (Please List) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|--|--|

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |   |  |
|---|--|
| 6. Do you have any allergies? (Please List) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|---|--|

\_\_\_\_\_

\_\_\_\_\_

- |  |  |
|--|--|
| 7. Have you ever had local anesthetic (freezing) at the dentist or doctor? | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 8. If yes, have you had any adverse reactions to anesthetic?               | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 9. Do you need to take antibiotics before going to the dentist?            | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 10. Have you ever had rheumatic fever as a child or an adult?              | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 11. How would you rate your level of activity?                             | <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High |
| 12. Do you smoke? If yes, how much do you smoke per day? _____             | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 13. Do you drink alcohol? If yes, how many drinks per week? _____          | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |
| 14. Do you wear footwear in the house? If yes, what type? _____            | <input type="checkbox"/> No <input type="checkbox"/> Yes                                     |

## Family History

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1. Please indicate any of the following disease or conditions that immediate members of your family have had:

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> Vascular Disease      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obstructive Lung Disease | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Bunions                  | <input type="checkbox"/> Flat feet |
| <input type="checkbox"/> Other (Specify) _____ |  |   |                                    |

## Personal History

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Please fill out the following questions as honestly and as accurately as possible:

1. Have you ever been admitted to or had surgeries in the hospital?  No  Yes  
(Please Indicate When and Why)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Do you have diabetes?

No  Yes

If yes, please answer the following

Type I  Type II

When were you diagnosed with diabetes? (MM/DD/YYYY) \_\_\_\_\_  No  Yes

Do you monitor your blood sugar? If yes, how often? \_\_\_\_\_  No  Yes

What is your blood sugar range? \_\_\_\_\_

Have you ever had a diabetic foot ulcer or infection?  No  Yes

Have you attended a diabetic clinic?  No  Yes

Do you suffer from diabetic neuropathy?  No  Yes

3. Please indicate if you have or have a history of any of the following conditions:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Hive/Rashes          |
| <input type="checkbox"/> Nervous System Problems | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Parkinson's Disease     | <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Muscular Dystrophy       | <input type="checkbox"/> COPD                 |
| <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> VRE                  |
| <input type="checkbox"/> MRSA                    | <input type="checkbox"/> C. Difficile        | <input type="checkbox"/> Tingling in Legs or Feet | <input type="checkbox"/> Eczema/Psoriasis     |
| <input type="checkbox"/> Cramps                  | <input type="checkbox"/> Muscle Weakness     | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Numbness                | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Emphysema            |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> Sciatica                 | <input type="checkbox"/> Hypo/Hyperthyroidism |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Depression           |

Cancer (If yes, what type?) \_\_\_\_\_

Heart attack (If yes, when?) \_\_\_\_\_

4. Do you have or have you been treated for Varicose Veins?  No  Yes  
If yes, when? (MM/DD/YYYY) \_\_\_\_\_

Have you worn or do you currently wear compression stockings?  No  Yes

5. Do you have or have you had poor circulation?  No  Yes  
If yes, does it affect your legs or feet?  No  Yes

**6. Please indicate if you've had any of the following blood problems:**

- Anemia
- Prolonged Bleeding
- Hepatitis A, B or C
- HIV
- Other (Specify) \_\_\_\_\_

**7. Please indicate if you have had any problems with any of the following:**

- Eyes
- Ears
- Stomach
- Bladder
- Throat
- Liver
- Nose
- Back
- Kidney

**Emergency Contacts**

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Please indicate who we can contact in case of emergency:

1st Contact Name	2nd Contact Name
Phone Number	Phone Number
Relation	Relation

**Informed Consent**

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To be completed by the patient or guardian prior to treatment:

I hereby request and consent to the performance of chiropractic treatment or other chiropractic procedures, including various modes of physical therapy by the chiropractor and/or anyone working in this clinic authorized by the chiropractor.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some slight risks to treatment, including, but not limited to pain, swelling, and infection. I do not expect the chiropractor to be able to anticipate and explain all risks and complications and I wish to rely on the chiropractor to exercise good judgments during the course of the procedure which the chiropractor feels at the time, based upon the facts then known, and is in my best interest.

I have read the above and consent. I understand this form covers the entire course of treatment for my present condition and for any future conditions for which I seek treatment. If at any time during the course of treatment I wish to withdraw my consent, I may do so.

Patient Name \_\_\_\_\_

Guardian (if applicable) \_\_\_\_\_

Signature \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_

**Cancellations and Missed Appointments**

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At Azilda Family Foot Care, we understand that sometimes events happen that could lead you to reschedule, postpone or cancel your appointment. Please understand that such changes can affect not only your personal health but that of other patients' as well.

We ask that our patients provide a minimum 48 hour notice for any cancellation or changes to your booked appointment. Any changes or cancellations made to appointments without 48 hour notice may be subject to a cancellation fee.

I have read and understand the above policy: \_\_\_\_\_

Patient Signature

**Would you like to join our email list?**

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**Yes**, I give you my consent to send me emails. I would like to join your email list to receive your newsletter, specials, upcoming events and other relevant content through Mailchimp. I am aware that I can unsubscribe at any time.

Signature \_\_\_\_\_

Email \_\_\_\_\_