Chiropody

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name ______________________ Email ______________________

We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Street ____________ Unit ________ City ________ Prov. ______ Postal Code ______

Date of Birth (MM-DD-YY) ________ Age ________ Gender ______ Occupation ____________

Shoe Size ______ Weight ______

How did you hear about us? ______________________

Do you have insurance coverage for orthotics? ☐ Yes ☐ No If yes, were you referred by your doctor? ☐ Yes ☐ No

Doctor's Name ____________ Phone ____________ Last Check-Up Date ________

Doctor's Street ____________ Unit ________ City ________ Prov. ______ Postal Code ______

Were you referred by another health care practitioner? If yes, who ______________________

Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other ________

Current Medications and Conditions Treating ______________________

Previous Major Illnesses/Operations (include dates) ______________________

Major Accidents ______________________

What is your primary complaint that you are seeking Chiropody for?

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Massage Addict

Health History

Medical Conditions, please check all that apply

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Stroke/ TIA
- ☐ High Cholesterol
- ☐ Lung/ Breathing disorders
- ☐ Developmental Conditions
- ☐ Fibromyalgia
- ☐ Sudden weight loss
- ☐ Diabetes
- ☐ Liver or Kidney disease
- ☐ Skin Diseases
- ☐ Leg Cramps
- ☐ Gout
- ☐ Epilepsy/ Seizures
- ☐ Chronic Fatigue
- ☐ High or Low blood pressure
- ☐ Heart Disease
- ☐ Poor circulation
- ☐ Thyroid issues
- ☐ Anxiety
- ☐ Depression
- ☐ Digestive Problems
- ☐ Difficulty healing
- ☐ Low immune system
- ☐ Cancer
- ☐ Osteoporosis/ Osteopenia
- ☐ Parkinson Disease
- ☐ Other

Medication

- ☐ I don't take medication
- ☐ I will provide a list to be photocopied on my visit
- ☐ Yes I take medication ____________

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Are you currently Pregnant or Breast feeding?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Have you ever been treated for a Communicable disease?

- ☐ Yes
- ☐ No

Do you Smoke?

- ☐ Yes
- ☐ No

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour.
- I understand that the Chiropodist is providing foot assessments and treatments within the scope of practice as defined by the College of Chiropodists of Ontario. I hereby voluntarily consent to my Chiropodist to treat me within the scope of practice at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.

Signature ____________ Today's Date ____________

Date updated ____________ Client initial ____________ Date updated ____________ Client initial ____________

Date updated ____________ Client initial ____________ Date updated ____________ Client initial ____________