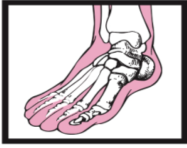

NIAGARA FOOT CARE CLINIC
AND ORTHOTIC CENTRE

Fitch Street Plaza
200 Fitch St. Unit 11.
Welland ON L3C 4V9
(905) 732-3668
www.niagarafootcareclinic.com

Jim Marando DCh. Spencer Farrow DCh. BSc. Diana Farrow DCh. BSc.
Christine Remigis BSc. DCh. Erin Panagakis RN IIWCC

*****Online Intake Forms*****

Today's Date: ______________________________

First Name: ______________________________ Last Name: ______________________________

Preferred Name: ______________________________ Birthdate (D/M/YY): ______________________________

Address: ____
(Street) (Apt)

____
(City) (Postal Code)

Phone: (Home) ______________________________ (Cell) ______________________________

(Business) ______________________________ (Other) ______________________________

Employer: ______________________________ Occupation: ______________________________

Would you like to receive email correspondence?

☐ Yes ☐ No Email: ______________________________

☐ Appointment reminders ☐ Financial documents ☐ Clinic newsletter

If yes, Check box for type of email correspondence you would like to receive?

Family Doctor: ______________________________ Address: ______________________________

In case of emergency, contact: ____

Relationship: ______________________________ Phone: ______________________________

Do you have Extended Health Care Coverage?

Policy Holder's Name: ______________________________ Policy Holder's Birthdate: ______________________________
(If different from patient)

Insurance Provider: ______________________________ Employer's Name: ______________________________

Plan number: ______________________________ ID number: ______________________________

How did you hear about our clinic? ☐ Phone Book ☐ Clinic Sign ☐ Website ☐ Friend/Relative/Doctor

Referral (Name): ____

Name: ______________________________ Date: ________________________________

Reason for today's visit: ____

When did your concern start? ____

Have you seen any other healthcare practitioner for the same concern? ______________________________

Have you taken any medication or remedies to help with the concern? ______________________________

Have you seen a Chiropodist/Podiatrist before? Yes ☐ No ☐

If yes, Name of Practitioner: __________________________________ Date of Last visit: ______________

Have you had custom made orthotics previously? Yes ☐ No ☐

If yes, Name of clinic: ______________________________________ Date of Last visit: ______________

Do you currently wear compression stockings (socks)? Yes ☐ No ☐

MEDICAL HISTORY

Height: __________ Weight: __________ Shoe size: __________

****

If you have been diagnosed with Diabetes/Borderline Diabetes, please answer the following:
Please Circle: **Type 1** or **Type 2** Date diagnosed? ________________________
What are your casual blood glucose levels: AM: _______ PM: _______ Average: ______
Do you feel Numbness/Tingling/Burning sensation in your feet or toes? Yes ☐ No ☐

****

Please indicate if you have, or have had, any of the following:

☐ AIDS/HIV
☐ Asthma
☐ Back Problems
☐ Bleeding Disorder
☐ Cancer
☐ Cholesterol
☐ Circulatory Problems
☐ Cerebral Palsy
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Gout
☐ Heart Attack,
Year: __________
☐ Heart Disease
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ Kidney Problems
☐ Liver Problems
☐ Multiple Sclerosis
☐ Osteoarthritis
☐ Parkinson's disease
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Shortness of Breath
☐ Stomach Ulcers
☐ Stroke
☐ Tuberculosis
☐ Other: ______________

ALLERGIES

Adhesive Tape Sulfa Local Anesthetics
Iodine Aspirin Penicillin
Other: ____

Do you smoke? Yes ☐ No ☐ Years: ________ Qty/Day: ________
Do you consume alcohol? Yes ☐ No ☐ Frequency: ____________________
Are you slow to heal after cuts? Yes ☐ No ☐
Do you bruise easily? Yes ☐ No ☐
Are you currently pregnant or nursing? Yes ☐ No ☐ N/A ☐

Surgeries (Back, Hip, Knee, Ankle, Foot):____

____

Hospital where surgeries performed: ____

Medications (include vitamins and oral contraceptives):______________________________

____