From Pain Relief to Wellness Care Naturally!!

PICKERING Wellness Centre

1128 Kingston Road
Pickering, ON, L1V 1B4
Tel: (905) 420-9494
Fax:(905) 420-9449
Email: pickeringwellness@yahoo.ca
Website: www.pickeringwellness.ca

CHIROPODY INTAKE HISTORY FORM

Please tell us about you

Name: Dr/Mr/Mrs/Miss_____
(**As it appears on your health card**)

Date: _____ Age: _____ Birthdate: d_____m_____y_____

Height: _____ Weight: _____ Shoe Size: _____

Footwear (Types worn): _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Occupation: _____

Home #: _____ Work#: _____ Cell# _____

Parents/Guardians names (If under 18)
Name: _____ Phone #: _____

Name: _____ Phone #: _____

Family Physician: _____

Who can we thank for referring you to us? _____

Other family members under our care: _____

CONTEXT OF CARE OVERVIEW;

Briefly explain your current foot issue and when it started: _____
_____

CURRENT MEDICAL HISTORY

Medications: _____
_____

Allergies: _____
_____

Surgeries: _____
_____

Are you being treated for or have been treated for the following conditions:

	Diabetes Type 1 Type 2		Blood disease
	Heart attack		HIV/AIDS
	Stroke		Hepatitis A B C
	High blood pressure		Liver
	Cholesterol		Kidney
	Heart issues		Thyroid
	Osteoarthritis		Breathing issues
	Rheumatoid arthritis		Depression
	Gout		Anxiety
	None apply		

Other: _____
_____

Our Privacy Policy at Pickering Wellness Center is in compliance with the privacy protocols and standards set by the College of College of Chiropodists of Ontario.

Print Name: _____

Signature X _____ **Date**_____

Date: _____

Name: _____ D.O.B: _____

C/C: _____
_____

Relevant Medical History: _____
_____

O/E: _____
_____

DORSAL

L R

PLANTAR

L R