MedRehab PHYSIOTHERAPY

CHIROPODY CONSENT AND HEALTH HISTORY

Name (Miss/Mrs/Ms/Mr):

_____
First Last

Address: _____ Apt: _____

City: _____ Postal Code: _____

Phone (home/cell): _____ Phone (business): _____

Date of Birth: _____ Occupation:_____

Do you have insurance: Yes ___ No ___

Chief Complaint:

_____

Medical Conditions - Please check the following if you have or previously had:

- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Dizziness / Black-outs
- ☐ Vision impairment
- ☐ Heart problems
- ☐ High / low blood pressure
- ☐ Chest pains
- ☐ Bleeding disorders
- ☐ Healing problems
- ☐ Foot ulcers
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Stomach problems
- ☐ Inflammatory bowel disease
- ☐ Gout
- ☐ Arthritis
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Genital-urinary infections
- ☐ Fracture(s)

If so, where: _____

- ☐ Hospitalization(s)

If so, for: _____

Other: _____

Medications (we can photocopy if you have a list):

_____ _____ _

_____ _____

Allergies**:**

_____

The D.Ch. (Chiropodist) treats the alignment of the foot and ankle using therapeutic, surgical and pharmaceutical techniques:

I hereby give permission to Chris Sweeting, D.Ch., to assess and recommend/administer treatment for my condition as deemed necessary. I intend this consent to apply to all my present and future chiropody care/visits.

_____ _____

Signature **Date**

New Patient Form

Chief complaint:
_____
_____
_____
_____

Podiatric History:
_____
_____
_____
_____

Medical History (including family, drinking, smoking, activities):
_____
_____
_____
_____
_____

Assessment	Right	Left
Vascular	DP PT Cap Refill: Claudication: Edema: Varicose veins: Atrophy:	DP PT Cap Refill: Claudication: Edema: Varicose veins: Atrophy:
Dermatological		
Biomechanical		

Neurological	Monofilament: /10 Vibration: /6		Monofilament: /10 Vibration: /6

DDx: _____

Diagnosis (Dx): _____