

Kitsilano Foot and Ankle Clinic - Client Intake Form

Name: _____

Address: _____

City/Prov/Postal Code: _____

E-mail: _____ **Date of birth:** YYYY-MM-DD **Occupation:** _____

Phone (home): _____ **Phone (cell):** _____

Height: _____ **Weight:** _____

Shoe SIZE: _____

Left foot: _____ **Right foot:** _____

Allergies to: _____

Food: _____

Medications: _____

Systemic conditions: _____

QUESTIONNAIRE:

1. Are you taking any medication(s)? If YES - what?

2. Are you currently under doctor's care?

3. List previous major:

Illnesses: _____

Accidents: _____

Surgeries: _____

Broken bones: _____

4. Any current or past treatment for foot pain?

5. Are you experiencing any problems with your feet? When did the problem start:

6. Person who referred you?

DATE: _____

Signature: _____