INTAKE FORM

Date: _____ □ Orthotics □ Podiatry

Name: _____ Date Of Birth: D_____M_____Y_____

Phone# (H) _____ (W) _____ (C) _____

E-Mail: _____

BOX#_____ Street Address: _____

Town:_____Postal Code: _____Height _____ Weight_____

1. Have you worn orthotics before? Y N If yes, name of supplier_____

Clinician's notes on orthotics:

_____

_____

2. Do you have diabetes? Y N If yes, since when_____Controlled By_____

3. Job title and place of employment: _____

4. Family Doctor: _____

Note: A medical letter will be sent to your Doctor(s) unless otherwise discussed with the Therapist.

6. Where is the pain? *Circle all that apply*: feet ankles knees hips back neck nails callus

_____

_____

_____

*7. CHIEF Complaint*_____

Has your *CHIEF Complaint* affected your activity level? □ Y □ N

8. Do you have insurance coverage for orthotics? N or Y: Insurance Company:_____

9. How did you find out about this clinic? □ Sign □ Doctor □ Newsletter □ Repeat Client □ Google
□ Word Of Mouth □ Purchased footwear here in the past
□Advertising *details:*_____

Consent Form

Please initial below to indicate that you have read and understand the following:

_____ MSI does not cover any of these services. Therefore, I am responsible to pay HealthWalks on the day of my service and to submit my receipt and paperwork to my private insurance company for reimbursement following my appointment.

____ The fee structure as outlined on the appointment confirmation email.

I have read the above and consent to accepting responsibility to pay for my treatment and to have intervention. Although complications are rare and risks are small, I understand that, depending on the purpose for my appointment, this may include the following:

Treatment	Potential Risks
FMT (Foot Mobility Therapy)	Fracture of the bones, muscular strain, ligamentous sprain, and/or dislocation of joints
TAM (Tool Assisted Massage)	Local discomfort during the treatment, reddening of the skin, superficial tissue bruising, and/or post-treatment soreness.
Gait Analysis	No risks
Weight Bearing & Non-Weight Bearing Analysis	No risks

Signature: Date:

_____

Office Use Only

TRIAL OF CORKS:
Patient calling us on (date): _____ Orthotics ordered on (date): _____

Product Ordered	Y	N	Brand **	Item#	Size	Quote	On hold	Ordered	Took home
Custom Orthotics									
Non Custom Orthotics									
1. Shoes									
2. Shoes									
Other									

Date Received	Date Picked Up	Comment
Repeat Rec?	Yes/no	How often?

Notes: