



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: _____