health Walks Inc.
Walk In...Dance Out

INTAKE FORM

Date: _____

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_____

2. Have you had podiatry treatment before? Y N If yes, name of provider_____

Therapist's notes:

_____

_____

2. Do you have diabetes? Y N If yes, since when_____Controlled By_____
Do you check your blood sugar daily? Y N What is your blood sugar range:_____
3. What type of shoe do you wear the most? _____ __Shoe Size_____
4. Job title and place of employment: _____

5. Family Doctor and specialist: _____

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 private insurance coverage? N or Y:
Insurance Company Name to receive correct paperwork:_____

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:*_____

10. Goal of today's visit: _____
(Example: assessment only, Orthotics if necessary, professional shoe fitting only, skin/nail care)

11. If this is a REPEAT visit for orthotics, what prompted this appointment?
• Orthotic Reminder Call • Change in symptoms • Insurance renewal • Orthotic wear and tear
• Reminder Email • repeat foot care

Consent Form

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

_____ MSI does not cover any of these services and we do not direct bill your insurance. Therefore, I am responsible to pay HealthWalks on the day of my service in full 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) not commonly needed	Fracture of the bones, muscular strain, ligamentous sprain, and/or dislocation of joints
TAM (Tool Assisted Massage) not commonly needed	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: _____

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

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