



CERTIFIED PEDORTHIST HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY					
				DATE: DD / MM / YYYY	
FIRST NAME	LAST NAME				
ADDRESS	CITY	POSTAL CODE	DATE OF BIRTH DD / MM / YYYY		
()	()	EMAIL ADDRESS (For Appointment Reminders)			
HOME PHONE	MOBILE PHONE				
EMPLOYER INFORMATION					
EMPLOYER		OCCUPATION			
ADDRESS	CITY	POSTAL CODE	() WORK PHONE		
HOW DID YOU HEAR ABOUT OUR OFFICE?					
<input type="checkbox"/> Internet	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Massage Therapist	<input type="checkbox"/> Friend / Family _____		
<input type="checkbox"/> Brochure	<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Postcard Mailer	<input type="checkbox"/> Other _____		
PREVIOUS PEDORTHIST	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DO YOU WEAR FOOT ORTHOTICS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PEDORTHISTS NAME	DATE OF LAST VISIT (APPROX.) DD / MM / YYYY		HOW LONG HAVE YOU WORN THEM? _____		
CLINIC NAME			HOW LONG SINCE YOUR LAST PAIR? _____		
PRIMARY CARE MEDICAL DOCTOR	OTHER PRACTITIONERS SEEN				
I authorize Target Therapeutics to send a report.			MESSAGE THERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____		
<input type="checkbox"/> NO <input type="checkbox"/> YES INITIAL _____			CHIROPRACTOR <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____		
			OSTEOPATHY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____		
			ACUPUNCTURE <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____		
			OTHER _____ <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____		
DOCTORS NAME	CITY				

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MEDICAL HISTORY/INFORMATION

EXISTING CONDITIONS

- Osteo Arthritis
- Rheumatoid Arthritis
- Athletes Foot
- Bunions
- Circulatory Condition
- Diabetes
- Gout
- Multiple Sclerosis
- Plantar Warts
- Polio
- Stroke
- Other _____

FOOTWEAR – list 1-5

(1 - most common, 5 - least common)

- Running Shoes
- Work Boot
- Casual Walker Shoe
- Winter Boot
- Men’s Dress Shoe
- Dress Low Heal
- High Heal
- Sandals
- Dress Flats
- Flip-flops

BODY MEASURMENTS

Foot Size _____

Foot Width _____

Weight _____

Height _____

- Please specify any other medical conditions you may have: _____

- Presence of internal pins, wires, artificial joints, special equipment: _____

- Do you have a history of sprained ankles? YES NO
If YES, please describe: _____

- Do you have a history of foot problems YES NO
If YES, please describe: _____

- Had a fracture? YES NO
If YES, please describe: _____

- Been hospitalized? YES NO
If YES, please describes: _____

- Have you had cancer? YES NO
If YES, please describe: _____

- When did this condition begin? _____

- What is the severity of pain? None - 1 2 3 4 5 6 7 8 9 10 - Worst

MEDICATION / SUPPLEMENTS

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Pain Killers | _____ |
| <input type="checkbox"/> Anti-anxiety | <input type="checkbox"/> Blood Thinners | _____ |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Vitamins/Herbs | _____ |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Essential Fats | _____ |