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 | DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE | ( ) MOBILE PHONE | EMAIL ADDRESS (For Appointment Reminders)

EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Postcard Mailer ☐ Other _____

PREVIOUS PEDORTHIST ☐ YES ☐ NO

PEDORTHISTS NAME | DD / MM / YYYY DATE OF LAST VISIT (APPROX.)

CLINIC NAME

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____

HOW LONG SINCE YOUR LAST PAIR? _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report.

☐ **NO** ☐ **YES** **INITIAL** _____

DOCTORS NAME | CITY

OTHER PRACTITIONERS SEEN

MESSAGE THERAPY	☐ Y ☐ N	DATE _____
CHIROPRACTOR	☐ Y ☐ N	DATE _____
OSTEOPATHY	☐ Y ☐ N	DATE _____
ACUPUNCTURE	☐ Y ☐ N	DATE _____
OTHER _____	☐ Y ☐ N	DATE _____

CERTIFIED PEDORTHIST HEALTH HISTORY FORM

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

- ☐ Anti-inflammatory
- ☐ Antibiotics
- ☐ Cholesterol
- ☐ Anti-anxiety
- ☐ Muscle Relaxants
- ☐ Antacids
- ☐ Blood Pressure
- ☐ Depression
- ☐ Pain Killers
- ☐ Blood Thinners
- ☐ Vitamins/Herbs
- ☐ Essential Fats
- ☐ Other: _____