PIED OUTAOUAIS

REGISTRATION QUESTIONNAIRE

Please complete this questionnaire which will be used to open your file.
All the information provided will remain confidential and is required by the laws regulating podiatry.

Surname: _____ Name: _____ Male ❑ Female ❑ Age: _____

Address: _____ Date of birth: _____ /_____ /_____
number street apartment DD MM YYYY

City: _____ Province: _____ Postal code: _____ Health insurance # (RAMQ):

Telephone (home): _____ Telephone (cell): _____ ↳_____

In case of emergency contact: _____
phone # name + relationship

E-mail: _____

Name of parents (if under 18 years old) or guardian: _____

What is your occupation: _____ mostly: ❑ standing ❑ sitting

Height: _____ Weight: _____ Shoe size: _____ Type of shoe _____

Regular sports and activities: _____

REASON OF VISIT

Reason of visit: _____

Description of pain (sharp, chronic, intermittent, etc): _____

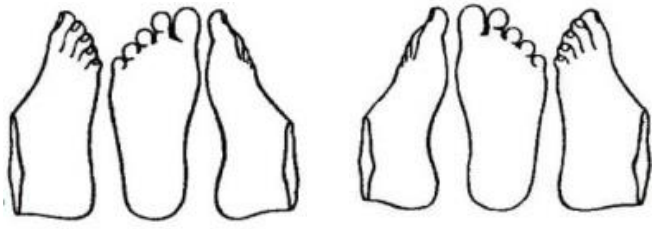
Since when: _____ days _____ months _____ years or indicate the date: _____

Moment of pain: ❑ Morning ❑ End of day ❑ Walking ❑ After activities ❑ _____

Select locations where you are experiencing pain:

- Ankle …… ❑ L ❑ R
- Knee …… ❑ L ❑ R
- Hip …… ❑ L ❑ R
- Lower back …… ❑ L ❑ R
- Sciatic nerve …… ❑ L ❑ R

Foot problems or pain (Indicate locations with an X):



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OTHER

Do you have insurance? ❑ Yes If so, which one? _____ ❑ No ❑ Do not know

How were you refered to us?

❑ Our website ❑ Friends-Family ❑ Family Doctor ❑ Youtube (video)

❑ Social network (Facebook) ❑ Daycare/school ❑ Newspaper ❑ Event

❑ Other health professional, name: _____

Do you have a family doctor?

❑ No ❑ Yes If so, what is his/her name? _____

Name of his clinic: _____ Telephone: ( ) _____

Are you currently followed by another health professional?

❑ No ❑ Yes If so, what is his/her name? _____

What profession is it? _____

Please complete the *BACK* of page

PODIATRIC HISTORY

Date of last podiatric visit: ❑ I have never visited a podiatrist ❑ less than a year ago ❑ 1-5 years ago ❑ Over 5 years ago

Have you ever had podiatric treatments such as:

❑ Plantar orthotics ❑ Ingrown toenail ❑ Plantar wart ❑ Surgery ❑ Corn/Calluses

MEDICAL HISTORY

	Yes	No
1. Have you ever suffered from food or medication allergies?……	❑	❑
Specify: _____ _____ _____		
2. Are you currently taking medication or natural products or have you taken some in the last 6 months? ……	❑	❑
❑ I will provide a full list of my medications (printed list from the pharmacist)		
or ☑ specify: _____ _____ _____		
_____ _____ _____		
_____ _____ _____		
3. Have you had a joint replacement? ❑ knee ❑ hip ……	❑	❑
4. Have you recently gained or lost a significant amount of weight? ……	❑	❑
5. Are you pregnant? ……	❑	❑
6. Are you breastfeeding? ……	❑	❑

Have you suffered or are you suffering from (specify if necessary):

7. Fracture or sprain? Specify:_____ .	❑	❑
8. Cardiac disorders (myocardial infarction, angina, valve problems, etc)? ……	❑	❑
9. Blood pressure issues? ❑ high pressure ❑ low pressure ……	❑	❑
10. Diabetes? Since what year? _____ ……	❑	❑
11. Arthritis? ……	❑	❑
12. Gout? ……	❑	❑
13. Phlebitis ou embolism? ……	❑	❑
13. Blood problems? ❑ hemophilia ❑ anemia ❑ other _____ ……	❑	❑
14. Stomach ulcer? ……	❑	❑
15. Skin disorder? ❑ eczema ❑ psoriasis ❑ other _____ ……	❑	❑
16. Liver problems? ❑ hepatitis B ❑ hepatitis C ❑ cirrhosis ……	❑	❑
17. Nervous disorders? ……	❑	❑
18. Thyroid disorders? ……	❑	❑
19. Kidney disorders? ……	❑	❑
20. Cancer? Type: _____ Year of diagnostic _____ ……	❑	❑
21. Sexually transmitted infections (STIs)?.....	❑	❑
22. Epilepsy? ……	❑	❑
23. Others? Specify: _____ _____ _____		

AGREEMENT AND CANCELLATION POLICY

The period allotted is reserved for for your appointments. If you are unable to attend the appointment, please notify us 24 hours in advance, otherwise a $25 fee will be charged. I certify that the information is true and complete to the best of my KNOWLEDGE. I further authorize my podiatrist to transmit and disclose my medical information to my insurance provider for the purpose of redemption and/or to my doctor if it is required by my medical situation.

PLEASE NOTE THAT PODIATRY CARE AND TREATMENTS ARE NOT COVERED BY RAMQ

Your number may, however, be necessary to transfer your file or review radiographs.

Signature: _____ Date: _____

(patient or guardian if under 14 years)