

NEW PATIENT QUESTIONNAIRE

Name:

Date of Birth: D/M/YEAR

Address:

Today's Date: D/M/YEAR

Telephone:

Email:

Doctors Name:

Referral Source:

Address:

Please sign: _____

MEDICAL HISTORY

Do you or any member of your family have a history of any of the following conditions: (Please tick)

<u>CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>DETAILS:</u>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clot (thrombosis)	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Angina	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach Ulcer/Dyspepsia	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced sensation in the feet/legs	<input type="checkbox"/>	<input type="checkbox"/>	
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Back Ache	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Psoriatic Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Please list):			

Please list any operations you have had:

Please list any tablets that are prescribed for you:

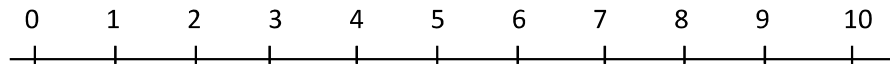
Does your occupation involve periods of standing or walking: Yes No

What makes it easier?

Please mark on the scale below the degree of discomfort you experience (please circle). If your pain varies between activities circle more than one score and indicate activity.

No pain

Severe pain



What weight are you approximately?

What is your Shoe size?

Which of the following shoe types do you wear? If you wear trainers, please list these under sports shoes:

- | | |
|---|---|
| <input type="checkbox"/> Lace ups, heel height less than ½ inch | <input type="checkbox"/> Slip ons, heel height less than ½ inch |
| <input type="checkbox"/> Lace ups, heel height less than 1 inch | <input type="checkbox"/> Slip ons, heel height less than 1 inch |
| <input type="checkbox"/> Lace ups, heel height more than one inch | <input type="checkbox"/> Slip ons, heel height more than 1 inch |
| <input type="checkbox"/> Sandal, Sling back | <input type="checkbox"/> Sandal, Slip on |
| <input type="checkbox"/> Sandal, Adjustable | <input type="checkbox"/> Other: (Please specify) |

In which of the following sports/activities do you participate (tick as many as appropriate):

- | | <i>Level</i> | <i>Frequency</i> |
|--|--|---|
| | <i>(Professional/ elite, amateur, hobby)</i> | <i>(Times per week/ month / year)</i> |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> High impact | <input type="checkbox"/> Step |
| <input type="checkbox"/> Athletics (please detail) | <input type="checkbox"/> Sprinting | <input type="checkbox"/> Middle distance |
| | <input type="checkbox"/> Long distance | <input type="checkbox"/> Field |
| | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Badminton | | |
| <input type="checkbox"/> Basketball | | |
| <input type="checkbox"/> Cricket | | |
| <input type="checkbox"/> Football | | |
| <input type="checkbox"/> Golf | | |
| <input type="checkbox"/> Gym | | |
| <input type="checkbox"/> Weights | <input type="checkbox"/> Treadmill | <input type="checkbox"/> Cycle / step / row |
| <input type="checkbox"/> Hockey | | |
| <input type="checkbox"/> Netball | | |
| <input type="checkbox"/> Rugby | | |
| <input type="checkbox"/> Sailing | | |
| <input type="checkbox"/> Skiing | | |
| <input type="checkbox"/> Squash | | |
| <input type="checkbox"/> Tennis | | |
| <input type="checkbox"/> Walking | | |
| <input type="checkbox"/> Other: (please detail) | | |