

BARE SOLES: ADVANCED NURSING FOOT CARE

New Client Intake & Medical History Form

Instructions:

Please complete this form in full and return it via email to **Baresolesinc@outlook.com** prior to our scheduled appointment.

SECTION 1: PATIENT IDENTIFICATION

- **Full Name:** _____
- **Date of Birth:** _____ **Age:** _____ **Sex:** _____
- **Primary Phone:** _____ **Email:** _____
- **Home Address:** _____
- **Past/Current Occupation:** _____

SECTION 2: APPOINTMENT LOGISTICS

- **Service Location:** ☐ Private Home ☐ Hospital/Facility
- **Facility Name (if applicable):** _____
- **Room/Bed Number:** _____

SECTION 3: CLINICAL Vitals & CRITICAL ALERTS

- **Height:** _____ **Weight:** _____
- **DIABETIC STATUS:** ☐ Type 1 ☐ Type 2 ☐ Pre-Diabetic ☐ No
 - *Years since diagnosis:* _____ *Management:* ☐ Insulin ☐ Oral
- **BLOOD THINNERS:** Are you currently taking anticoagulants? ☐ Yes ☐ No
- **ALLERGIES:** (Latex, Alcohol, Adhesives, Fragrances)
 - ☐ No Known Allergies ☐ Yes: _____

SECTION 4: MEDICAL HISTORY & FOOT HEALTH

Please check [X] if you have ever experienced the following: ☐ Foot/Leg Ulcers or Sores ☐ Neuropathy (Numbness/Tingling) ☐ Poor Circulation ☐ History of Fungal Infections ☐ Leg or Foot Pain ☐ Previous Professional Foot Care ☐ Use of Medicated Wart/Corn Treatments

- **Do you wear orthotics?** ☐ Yes ☐ No
- **Do you go barefoot?** ☐ Yes ☐ No
- **What is your primary concern for today's visit?**

SECTION 5: CURRENT MEDICATIONS

Please list all current medications, including over-the-counter and supplements:

SECTION 6: MANDATORY WELLNESS SCREENING

Are you currently experiencing:

- **Respiratory/Viral:** Fever, new/worsening cough, shortness of breath, sore throat, loss of taste/smell? ☐ Yes ☐ No
- **Functional:** Recent falls, delirium, or acute decline in mobility? ☐ Yes ☐ No

CONSENT & AUTHORIZATION I certify that the above information is correct to the best of my knowledge. I understand that the foot care provider will perform assessments, nail/callous reduction, and provide health teaching.

Signature (Client or Power of Attorney): _____

Date: _____