Please complete this form and bring it to your first appointment

FOOT & HEALTH CLINIC

A STEP BEYOND IN CARE
728 BURLOAK DRIVE, UNIT B3, BURLINGTON ONTARIO L7L 0B1
TEL (905) 632-1414 FAX (905) 632-5477

Personal Information:

Name: ____
(Title) (Last Name) (First Name)

Address: ____
(Full Street Address)

____
(City/Town) Postal code)

Email: ____

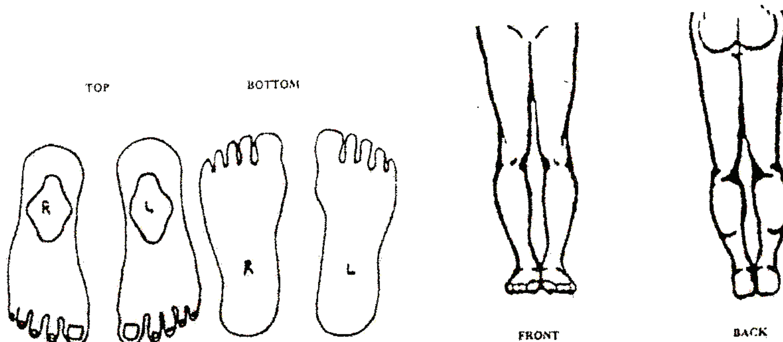
Home Phone: ______________________ Work Number: ____________

Occupation: ______________________ Age: ____ Date of Birth ____________
Day /month /year

Family Doctor: ____________________ Phone Number ____________________

Reason for Visit: ____
Previous care by a Chiropodist? ☐ or Podiatrist? ☐ If yes date of last Visit: ____________
Referred to this Clinic through:
☐ Friend ____________________ ☐ Doctor ____________________
☐ Newspaper Ad ____________________ ☐ Other ____________________

On the Diagrams provided below, mark the areas on your lower limbs and feet which you feel best represents the pain or sensation you are experiencing.



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Health History

Please check those items that specifically relate to your medical history. Please answer these questions carefully, as they will be considered in establishing a suitable treatment plan for you.

Head/Ears/Eyes/Nose/Throat

☐ Frequent Headaches ☐ Ringing in Ears ☐ Glasses/Contacts Recurrent ☐ Nose
☐ Previous Head Injury ☐ Difficulty Hearing ☐ Vision Problems Infections? ☐Throat
☐ Fainting Spells ☐ Dizziness ☐ Convulsions/Seizures
☐ Other? Please Specify:____

Cardiovascular System

☐ High Blood Pressure ☐ Heart Disease ☐ Chest Pain ☐ Poor Circulation
☐ Low Blood Pressure ☐ Heart Attack/Stroke ☐ Bleeding Disorders ☐ Numbness
☐ Angina ☐ Varicose veins ☐ Leg Cramps ☐ Swollen Ankles
☐ Other? Please Specify:____

Respiratory System

☐ Shortness of Breath ☐ Smoker Number of Cigarettes smoked daily ______
☐ Asthma ☐ Non Smoker ☐ Smoked in the past? How Long? _____
☐ Other? Please Specify:____

Endocrine System

☐ Diabetes ☐ Thyroid Condition ☐ Addison's Disease ☐ Cushing's Syndrome
☐ Other? Please Specify:____

Musculoskeletal

☐ Joint Pain ☐ Joint Stiffness ☐ Joint Swelling ☐ Limited Movement
Area: _______________ Area: ______________ Area: ________________ Area:__________________
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Muscle Weakness
☐ Have you ever broken/fractured any bones? Where? ______________________________
☐ Other? Please Specify:____

Skin and Nails

☐ Dry/Cracking Skin ☐ Dry/Brittle Nails ☐ Discolored Nails ☐ Warts
☐ Moist (sweaty) Skin ☐ Rashes/Itching ☐ Fungal Infections ☐ Foot/Leg Ulcers

Surgery

☐ Foot Surgery ☐ Joint Replacements ☐ Organ Transplant
☐ Other? Please Specify: ____

Allergies

☐ Have you ever had any allergies?
Please Specify: ____

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Psychological

☐ Depression ☐ Anxiety/Nervousness ☐ Other? Please Specify:________________________________

Other

☐ Have you ever been hospitalized? Reason: ____

If there are any other relevant medical conditions not covered on this form please outline them here:

____
____
____

Medications

Please list any medications that you are taking below:

____
____
____
____
____
____
____
____
____

Have you ever experienced any side effects from the local anesthetics, penicillin or other medications? If so please specify:____

Please inform the Chiropodist if you have ever tested positive for HIV or hepatitis.

I acknowledge that all of the above information is correct. I understand that this information is confidential and will be used for no other purpose than for the chiropodist's clinical records and to comply with legal and regulatory requirements of The College of Chiropodists of Ontario.

Informed Consent to Chiropodist Care

I hereby give permission for the examination and assessment of my feet, as well as give consent to perform such diagnostic procedures as may be deemed necessary. I understand and am informed that, as in all health care, in the practice of chiropody there may be some very slight risks to treatment. I wish to rely on the chiropodist to exercise good judgment during the course of the procedure which the chiropodist feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to treatment by the chiropodist. I intend that this consent form to cover the entire course of my treatment for my present or any other future condition(s).

______________________________ ______________________________
Signature of Patient Date Signed

______________________________ ______________________________
Signature of Parent (if patient under 18yrs of age) Date Signed