Welcome to Advanced Foot & Orthotic Clinic

263 Midland Ave ● 705-526-6363 ● www.advancedfootclinic.ca

NAME _____ BIRTH DATE _____
First Last M / D / Y

MAILING ADDRESS_____ CITY_____ POSTAL CODE_____

P.O. BOX _____APT. _____ Phone Number (____)____-____ ☐ Alternative (____)____-_____ ☐
Please check the box of the preferred number to be reached

EMAIL: _____ ☐ I provide consent to receive emails
Adding your email to our mailing list will allow us to keep you up to date on events at the clinic as well as important information regarding your foot health. You have the option to unsubscribe at any time!

Occupation: _____ Company Name: _____

• How did you hear about the clinic today? (Choose all that apply)

- ☐ Post Card In Mail
- ☐ Website
- ☐ Shop Midland
- ☐ Midland Mirror
- ☐ SNAPD
- ☐ Yellow Pages / ☐ Yellow Pages Online
- ☐ Facebook
- ☐ Google Search
- ☐ Welcome Wagon
- ☐ Magnet Sign/Signs out front
- ☐ Dr. Referral/ ☐ Spa Referral
- ☐ Other: _____
- ☐ Word of Mouth – *Who may we thank for your referral?* _____

• Family Doctor: Name:_____ Location:_____ Phone:_____

• Do you consent to our clinic sending a report to your family doctor, if required? ☐ Yes ☐ No

• Have you had previous Chiropody/ Foot Care? ☐ Yes ☐ No If YES where:_____

• What is your reason for you visit TODAY? (Choose all that apply)

- ☐ Nail Care
- ☐ Corn/Callus Care
- ☐ Warts
- ☐ Diabetic Screening/ Foot Care
- ☐ Assessment
- ☐ Orthotics
- ☐ Orthopaedic/Custom Shoes
- ☐ Foot Pain
- ☐ Ingrown Toenail
- ☐ Other:_____
- ☐ My Concern is Painful
- ☐ My Concern is NOT Painful

- Pain Scale ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *1 – Not much pain, 10 being the most pain you have ever felt.*
- I have had this Concern for? Years: _____Months:_____Weeks:_____Days_____
- This concern is affecting my daily life or lifestyle ☐ Yes ☐ No

What are your expectations from your visit today?_____
_____

Note: Privacy of personal information is an important principle to Advanced Foot & Orthotic Clinic. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. If you have not yet been offered, please ask to review a copy of our Privacy Policy. If required for your case, we will be in contact with your Family Physician.

Office Use Only: Date of Initial Assessment:_____ Time of Appointment:_____

Medical Questionnaire

The answers to this medical questionnaire help us to identify the cause of your foot problems. All information is confidential!

- Do you consider yourself to be in good health? □ Yes □ No
- Do you consider yourself to be a good healer? □ Yes □ No
- Do you have any problems with your immune system? □ Yes □ No
- Are you taking any medications? This includes oral contraceptives & supplements. □ Yes □ No

Please list your Medications & Supplements:

_____

_____

_____

- Do you have any allergies? (please list below) □ Yes □ No
  - □ Drugs_____
  - □ Adhesive Tape_____
  - □ Food:_____
  - □ Environmental:_____
- Have you ever had local anaesthetic (freezing) at the dentist or doctor? □ Yes □ No
- Have you ever had rheumatic fever as a child or as an adult? □ Yes □ No
- Do you need to take antibiotics before going to the dentist? □ Yes □ No
- Do you smoke? □ Yes □ No
- Do you drink alcohol? □ Yes – if yes, how many per week?_____ □ No
- How would you rate your level of activity □Low □Moderate □ High
- Do you wear footwear in the house? □ Yes □ No

Family History: Please check any of the following diseases/conditions that **members of your family** have had. This relates to your mother, father, sister and brother.

- □ Heart Disease
- □ Stroke
- □ High Blood Pressure
- □ Diabetes
- □ Vascular Disease
- □ Asthma
- □ Cancer
- □ Obstructive Lung Disease
- □ Flat Feet
- □ Bunions
- □ Psoriasis
- □ Eczema
- □ Other:_____

Personal History

- Have you ever been admitted or had surgeries in the hospital? □ Yes □ No
  If yes, what were the reasons and dates: _____

- □ Diabetes
- □ Car Accident
- □ Injury
- □ Breathing Problems/Asthma
- □ Infections
- □ Stroke
- □ Heart Condition
- □ Childbirth
- □ Surgery
- □ Artificial Joints
- □ Organ Transplant:_____
- □ Other:_____

Please continue answering questions on page 3

Medical Questionnaire Continued

- Do you have diabetes? ☐ Yes ☐ No
  - If yes, do you check your blood sugar? ☐ Yes ☐ No
  - If yes, how often do you check your blood sugar levels? _____
  - If yes, what is typical blood sugar level range? _____
  - If yes, what is your HA1C? _____
- Have you ever attended a Diabetic Clinic? ☐ Yes ☐ No
- Have you ever had a diabetic foot ulcer or infection? ☐ Yes ☐ No
- Have you ever had a head injury? ☐ Yes ☐ No
- Do you suffer from migraines or headaches? ☐ Yes ☐ No
- Do you have any of the following nervous system problems? ☐ Yes ☐ No
  - ☐ Epilepsy ☐ Parkinson's Disease ☐ Muscular Dystrophy
  - ☐ Seizures ☐ Cerebral Palsy
- Do you have or have you had any problems with your:
  - Eyes ☐ Yes ☐ No
  - Ears ☐ Yes ☐ No
  - Nose ☐ Yes ☐ No
  - Throat ☐ Yes ☐ No
- Do you have or have you had high cholesterol? ☐ Yes ☐ No
- Do you have or have you had a blood pressure condition? ☐ Yes ☐ No
- Do you have or have you had a heart condition? ☐ Yes ☐ No
- Have you had a stroke? ☐Yes ☐ No If yes, when? _____
- Do you have or have you been treated for Varicose Veins? ☐Yes ☐ No If yes, when? _____
- Do you have or have you had poor circulation? ☐Yes ☐ No Does it affect your legs/feet ☐Yes ☐ No
- Do you have or have you had problems with your blood? (eg. anemia, prolonged bleeding) ☐ Yes ☐ No
- Have you ever had the following blood-born infections?
  - ☐ Hepatitis A, B, or C ☐ MRSA ☐ VRE
  - ☐ HIV ☐ C.difficle ☐ Other:_____
- Do you get cramps, muscle weakness, numbness or tingling in legs or feet? ☐ Yes ☐ No
- Do you have or have you had lung or breathing problems ☐ Yes ☐ No
- Do you have a history of tuberculosis? ☐ Yes ☐ No
- Do you have any problems with your:
  - ☐ Liver ☐ Bladder ☐ Underactive thyroid gland
  - ☐ Stomach ☐ Overactive thyroid gland ☐ Gall bladder

Please continue answering questions on page 4

Medical Questionnaire Continued

- Do you have osteoporosis? □ Yes □ No
- Do you have or have you had gout? □ Yes □ No
- Do you have arthritis? □ Yes □ No
- Do you have fibromyalgia? □ Yes □ No
- Do you have any back pain? □Yes □ No Do you suffer from Sciatica? □ Yes □ No
- Do you have or have you had any of the following skin problems?
  - □ Rashes □ Birth marks □ Other:_____
  - □ Hives □ Moles
- Are you experiencing any anxiety, difficulty sleeping or depression? □ Yes □ No
- What is your shoe size? _____

Informed Consent to Chiropody Treatment

I hereby request and consent to the performance of chiropody treatment and other chiropody procedures, including various modes of physical therapy by the chiropodist and/or anyone working in this clinic authorized by the chiropodist.

I further understand and am informed that, as in all health care, in the practice of chiropody there are some very slight risks to treatment, including, but not limited to pain, swelling, and infection. I do not expect the chiropodist to be able to anticipate and explain all risks and complications. I wish to rely on the chiropodist's judgement in regards to my appointment and my care, based upon the facts then known, and what is in my best interest.

I have read the above and consent. By signing below I agree to the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. If at any time during the course of treatment, I wish to withdraw my consent, I may do so.

To be completed by the Patient or Guardian prior to Treatment:

Signature: _____

Print Name of Guardian: (If applicable) _____

Date: _____

Cancellation Policy

At Advanced Foot & Orthotic Clinic your health and well being are our top priority! We want to ensure that you receive the highest quality of care and treatment. To do this we require that all of our patients arrive on time (or early) for their appointments. Your appointment time is reserved exclusively for you. There will be no charge for appointment cancellations provided that two working days notice is given. Advanced Foot & Orthotic Clinic reserves the right to charge $35.00 for any missed appointments if the required two workings days notice is not given. _____ (initial).

Signature: _____ Date: _____