Welcome to Advanced Foot & Orthotic Clinic

263 Midland Ave ● 705-526-6363 ● www.advancedfootclinic.ca
Fax: 705-526-7101 ● info@advancedfootclinic.ca

NAME _____BIRTH DATE _____
First Last M / D / Y

MAILING ADDRESS_____ CITY_____ POSTAL CODE_____

P.O. BOX _____APT. _____Phone Number (____)_____-_____ Alternative(____)_____-_____
(circle one) Home Cell Work (circle one) Home Cell Work

EMAIL: _____

☐ I provide consent to receive emails for communication purposes

OCCUPATION: _____ Company Name: _____

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

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

•Family Doctor:

Name:_____Location:_____Phone:_____

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

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

- ☐ Nail Care
- ☐ Corn/Callus Care
- ☐ Warts
- ☐ DiabeticScreening/FootCare
- ☐ Assessment
- ☐ Orthotics
- ☐ Orthopaedic/Custom Shoes
- ☐ Foot Pain
- ☐ Ingrown Toenail
- ☐ Fungal toe nails
- ☐ Other:_____

- Pain Scale ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *1 - not much pain, 10 - 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. _____ (initial).

Please continue answering questions on page 2

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 or attach a list:

_____
_____
_____

- **Do you have any allergies? (please list below)** □ Yes □ No
  - □ Drugs_____ □ Food:_____
  - □ Adhesive Tape_____ □ Environmental:_____
- Have you ever had local anaesthetic (freezing) at the dentist or doctor? □ 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 □ No If yes, how many per week?_____
- Do you use recreational drugs? □ Yes □ No
- How would you rate your level of activity? □Low □Moderate □ High
- Do you wear footwear in the house? □ Yes □ No
- What size footwear do you wear? _____
- Have you ever worn orthotics? □ Yes □ No If yes, when? _____
  If yes, why? _____

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

Personal History:

□ **Have you ever been admitted to/or had surgeries in the hospital?** □ Yes □ No

If yes, what were the reasons and dates:

_____
_____

Please continue answering questions on page 3

Medical Questionnaire Continued

Please indicate if you have or have had a history of any of the following:

- ☐ Head injury
- ☐ Migraines/Headache
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Child Birth
- ☐ High Cholesterol
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hypo/hyperthyroidism
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Eczema/Psoriasis
- ☐ Hives/Rashes
- ☐ MRSA
- ☐ C. Difficile
- ☐ VRE
- ☐ Tuberculosis
- ☐ Insomnia
- ☐ Depression
- ☐ Numbness
- ☐ Tingling in legs or feet
- ☐ Nervous System Problems
- ☐ Parkinson's disease
- ☐ Epilepsy
- ☐ Cerebral palsy
- ☐ Seizures
- ☐ Muscular Dystrophy
- ☐ Muscle weakness
- ☐ Sciatica
- ☐ Fibromyalgia
- ☐ Heart attack (if yes, when?)_____
- ☐ Stroke (if yes, when?)_____
- ☐ Cancer (if yes, what type?)_____
- ☐ Other:_____

- **Do you have diabetes?** ☐ Yes ☐ No
  - ☐ Type I ☐ Type II
  - 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

- **Do you have or have you been treated for Varicose Veins?** ☐ Yes ☐ No
  If yes, when?_____
- **Have you been diagnosed or have you been treated for poor circulation?** ☐ Yes ☐ No
  If yes, does it affect your legs or feet? ☐ Yes ☐ No
- **Please indicate if you have had any of the following blood problems?**
  - ☐ Anemia
  - ☐ Prolonged bleeding
  - ☐ HIV
  - ☐ Hepatitis A, B, or C
  - ☐ Other: _____
- **Please indicate if you have had any problems with any of the following:**
  - ☐ Eyes
  - ☐ Ears
  - ☐ Stomach
  - ☐ Bladder
  - ☐ Throat
  - ☐ Liver
  - ☐ Nose
  - ☐ Back
  - ☐ Kidney
  - ☐ Lungs

Please continue answering questions on page 4

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 wellbeing 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 a cancellation fee for any missed appointments if the required two workings days' notice is not given. _____ (initial).

Signature: _____ Date: _____