Brampton Foot Clinic

First Name:____________________ **Middle Initial:** ______ **Last Name:**______________________

Date of Birth (mm/dd/yyyy)____________________ **Sex:** ☐ **M** ☐ **F**

Address:__________________________________

City:___________________ **Province**__________

Postal Code:____________

Occupation:____________________________

Primary Phone #________________________

Secondary Phone #______________________

E-mail Address: ________________________

Parent/Guardian (if child under 16years):____

Family Physician:____

Address:_____________________ **City:**_______________ **Phone #:**_________________________

How did you hear about us?

- ☐ Family and Friends
- ☐ Driving By
- ☐ Health Care Professional --> _____________________________
- ☐ Bench/Bus Stop Signs
- ☐ Powerade Centre
- ☐ Yellow Pages
- ☐ Internet Search
- Other: __________________

Please check what applies to you:

I AM HERE BECAUSE OF MY....

- ☐ LEFT FOOT
- ☐ RIGHT FOOT
- ☐ KNEES
- ☐ BACK
- ☐ HIPS
- ☐ LEGS

WHAT ARE YOU FEELING?

____

____

____

____

____

____

ACTIVITES/SPORTS? ____

FOOTWEAR?____

WEIGHT GAIN/LOSS?________________

CURRENT WEIGHT ____________ **HEIGHT?** __________ **SHOE SIZE?**_____________

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Please check what applies to you:

☐ High blood pressure? ☐ Cholesterol? ☐ Heart condition? ☐ Osteoarthritis? ☐ Rheumatoid Arthritis? ☐ Diabetes? -> ☐ Type I or ☐ Type II -> How long ____________	☐ Headaches? ☐ Vision problems? ☐ Low blood pressure? ☐ Thyroid? ☐ Cancer? ☐ Skin condition? ☐ Asthma?	☐ HIV/AIDS? ☐ Hepatitis? ☐ Bowel/Urine trouble? ☐ Developmental condition? ☐ Any other conditions: ____________________ ____________________

Please list your current medications/vitamins:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Past Injuries/Surgeries:

______________________________ ______________________________

______________________________ ______________________________

What are you Allergic to?

☐ Antibiotics -> ____________________ ☐ Anesthetic (Freezing) -> ____________ ☐ Medication ->____________________ ☐ Latex ☐ Seasonal	Any Other Allergies: ____________________________ ____________________________ ☐ No known allergies

If Applicable, are you currently ☐ Nursing? ☐ Pregnant?

____

Any other information you would like to share with the Chiropodist?

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Consent Terms:

I understand that the Chiropodist is providing foot assessments and treatments within the scope of practice as defined by the College of Chiropodists of Ontario. I hereby consent to my Chiropodist to treat me within the scope of practice. I allow photographs of my feet to be taken for monitoring and education purposes.

I authorize release of any medical information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, as well as other data pertinent to my treatment to my physician(s) or other health care providers currently involved in my care.

I understand that I am financially responsible for all charges, whether covered by my extended insurance plan or not. I understand that chiropody service fees are payable at the time of the appointment. I acknowledge that custom made/ordered devices are not refundable.

Cancellation Policy:

We try to provide exceptional service to our patients. To help us achieve this, we ask that you provide us with at least 24 business hours notice if you need to reschedule or cancel your appointment, otherwise a $40 missed appointment charge will apply. Thank you for your consideration.

If the patient is under 16 years of age the form must be signed by a parent or guardian.

Patients Signature: ________________________________ **Date:** ________________________

Print Name: ______________________________________