THE FOOT CLINIC

PATIENT INFORMATION FORM:

FIRST NAME:	LAST NAME:
DATE OF BIRTH *(d/m/yyyy)*:	SEX: ☐M ☐F
ADDRESS:	
CITY:	POSTAL CODE:
HOME PHONE #:	WORK PHONE #:
CELL PHONE #:	OTHER #:
E-MAIL ADDRESS:	
OCCUPATION:	EMPLOYER:
PARENT/GUARDIAN NAMES *(if child is under 16)*:	
MOTHER:	FATHER:

FAMILY PHYSICIAN:	PHONE #:
ADDRESS:	CITY:
NAME OF HEALTH INSURER:	
POLICY NUMBER:	GROUP PLAN:

HOW DID YOU HEAR ABOUT THE FOOT CLINIC?

☐ INTERNET ☐ NEWSPAPER
☐ YELLOW PAGES ☐ HEALTH CARE PROFESSIONAL
☐ FAMILY AND FRIENDS ☐ OTHER

WHEN DID YOUR FOOT PROBLEM BEGIN?

MY FOOT PROBLEMS INVOLVE:	**BRIEFLY DESCRIBE YOUR CURRENT FOOT PROBLEMS:**
☐ LEFT FOOT ☐ RIGHT FOOT ☐ BOTH FEET ☐ OTHER	

SHOE SIZE:	SHOE WIDTH:	HEEL HEIGHT:	SHOE STYLES:
HEIGHT: WEIGHT:	CHANGE OF WEIGHT IN THE PAST 2 YEARS: LBS GAINED:		LBS LOST:
TYPE OF SHOES WORN AT WORK:		TYPE OF SHOES WORN AT HOME:	
LEISURE ACTIVITIES *(Sports/Excercise)*:			
HAVE YOU HAD ANY PREVIOUS CARE BY A FOOT SPECIALIST? ☐ YES ☐ NO			

Please Turn to Second Page

PLEASE ANSWER THE FOLLOWING QUESTIONS:

HAVE YOU EVER BEEN TREATED FOR:

- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ BLOOD DISEASE
- ☐ BONE DISEASE
- ☐ CANCER
- ☐ CHOLESTEROL
- ☐ DEPRESSION
- ☐ DIABETES: Type 1 Type 2 How Long?_____
- ☐ EPILEPSY
- ☐ GOUT
- ☐ HEPATITIS
- ☐ HEART TROUBLE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ LIVER DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ SKIN DISORDER
- ☐ STOMACH / BOWEL TROUBLE
- ☐ THYROID PROBLEM
- ☐ URINARY PROBLEM
- ☐ NONE APPLY

☐ OTHER *Please Explain:*_____

PLEASE LIST ALL CURRENT MEDICATIONS:_____

HAVE YOU HAD ANY INJURIES, FRACTURES OR SURGERIES? PLEASE LIST BELOW AND EXPLAIN.	
FOOT:	ANKLE:
KNEE:	LEG:
HIP:	BACK:

DO YOU HAVE ANY KNOWN ALLERGIES TO:		
LOCAL ANAESTHETICS? *(i.e Xylocaine, Novocaine)*	☐ YES	☐ NO
ADHESIVE TAPE / BAND-AIDS?	☐ YES	☐ NO
ANTIBIOTICS *(i.e Penecillin Base)*	☐ YES	☐ NO
OTHER *Please Explain:*		

ARE YOU SLOW TO HEAL AFTER CUTS?	☐ YES	☐ NO
ARE YOU CURRENTLY PREGNANT OR NURSING?	☐ YES	☐ NO

Our Privacy Policy at the Foot Clinic is in compliance with the privacy protocols and standards set by the Ontario College of Chiropodists. Your Foot health is our business and our office is commited to the highest standards of Chiropodial/Podiatric Medicine. If the patient is under 16 years of age the form must be signed by a parent or guardian.

Patients Signature: _____ **Date:** _____

Please Print Name: _____

THE FOOT CLINIC

Orangeville Office

285 Broadway
Orangeville L9W 1L2

Phone: 519.942.4705