RICHVIEW FOOT CARE CLINIC 416.242.7802

Custom Made Orthotics • Diabetic Foot Care • Nail Disorders • Corn/Callus Removal • Childhood Foot Conditions • Sports Related Injuries

Please help us get to know you better by providing the following information: please print

First name:_____Last name:_____Title: _____

Address:_____City:_____Postal Code: _____

Phone: (H)_____(C)_____(W) _____

Date of birth: (D/M/Y)_____Email address:_____Occupation: _____

Would you like us to confirm appointment? Email: ☐yes ☐No Phone: ☐ yes ☐ No

Emergency contact:_____Relationship:_____Phone: _____

How did you hear about our clinic? (please specify)

Internet ☐ Doctor ☐ Other ☐_____Friend / family ☐ _____

Help us help you !

Please answer the following foot related questions:

Your foot problems involve:

☐ Left foot only ☐ Right foot only ☐ Both feet

Why are you here today? Explain your current foot problem

_____

_____

Is this problem getting:

☐ Worse ☐ Better ☐ Same / no change

Have you ever had treatment for this problem? ☐ yes ☐ No

Have you had foot x-rays: ☐ yes ☐ No When: _____

Have you ever been treated for: (systemic conditions)

☐ Diabetes How long have you had it :_____

☐ Heart disease ☐ Liver disease

☐ High blood pressure ☐ Skin disorder

☐ HIV/Aids ☐ Arthritis

☐ Cancer ☐ Shortness of breath

☐ Stroke ☐ High cholesterol

☐ Depression ☐ Stomach / Bowel issues

☐ None Apply ☐ Other: _____

Cont. _____

What is your current:

Height: _____ Weight: _____ Shoe size: _____

On average how much are you on your feet?

☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

What type of shoes do you wear most :

Work:_____Leisure: _____

Do you use custom orthotics (shoe inserts)? ☐ yes ☐ No

Check any sports or activities you participate in <u>regularly</u>:

☐ Walking How long do you walk :_____minutes

☐ Running How far do you run :_____Km____X per week

☐ Soccer ☐ Skiing ☐ Aerobics ☐ Golf

Other: _____

Have you ever been treated for: (foot specific conditions)

☐ Warts ☐ Gout ☐ Broken feet / leg

☐ Calluses ☐ Corns ☐ Neuroma

☐ Bunions ☐ Flat feet ☐ Ingrown nails

☐ Hammer toes ☐ Ankle injury ☐ Ulcerations

☐ Heel pain ☐ Childhood Foot Problems

Do you have any known allergies to:

Anesthetics? ☐ yes ☐ No Tape/band aids? ☐ yes ☐ No

No allergies ☐ Other: _____

Patient Physicians & Medical Specialists:

Physician:_____Phone: _____

Has your doctor treated your foot condition? □ yes □ no

Other Doctor:_____Phone:_____

_____ _____

_____

Please list your current Rx medications:

(If you have a list our office staff can photocopy and attach it)

_____

Type of Doctor: _____

Social History:

Do you smoke? □ yes □ no If yes, how much ? _____

Do you use alcohol? □ yes □ no If yes, how much ? _____

Are you pregnant? □ yes □ no If yes, when is your due date ? _____

Do you take blood thinners? □ yes □ no If yes, when was your last INR ?_____What was the value ? _____

Have you had previous surgeries? □ yes □ no If yes, please explain ? _____

Have you ever fainted? □ yes □ no If yes, please explain ? _____

Patient's Consent: (must be completed and signed before foot exam)

☐ I hereby allow and consent to examination and treatment by the Chiropodist and allow photographs of treatment areas to be taken for the purposes of monitoring my foot conditions.

☐ I consent / allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information. I understand and am informed that, as in all health care, in the practice of Chiropody there are some very slight risks to treatment. I wish to rely on the Chiropodist to exercise judgment during the course of the procedure which the Chiropodist feels at the time

☐ I consent / allow the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.

☐ I understand that Chiropody is <u>not</u> an OHIP covered service and I am financially responsible for all charges whether covered by my health insurance plan or not.

☐ I understand that service fees are payable at the time service is provided.

☐ I understand that if I do not cancel within 24 hours I will be charge $50.00 for missed visit

Patient's Signature (or guardian):_____Date: _____

Richview Foot Care Clinic Inc promises to treat your personal information with respect. Our privacy protocols comply with provincial privacy legislation, the standards of the College of Chiropodists of Ontario and the law.

Chiropodist Signature:_____Date: _____

□ **Acosta Michael D.Ch., BSc.**