# SIMCOE FOOT CARE & CUSTOM ORTHOTIC CENTRE

Welcome to Simcoe Foot Care & Custom Orthotic Centre! We are dedicated to providing exceptional foot care for people of all ages. Please help us get to know you better by providing the following information.

Name: ______________________________________________ Address: _________________________________

__________________________________________ City: ________________________ Postal Code: ____________

Home Phone #: _______________________ (cell) ________________________ (work) ________________________

Please Circle: Male Female Date of Birth: (month) ________ (day) ________ (year) __________

Email: _____________________________________ Family Physician: ____________________________________

*Preferred Contact Method: (Please circle one)* *Home Phone* *Cell Phone* *Work Phone* *Email*

How did you hear about our Clinic? Family/Friend: ________________________________________

☐ Physician ☐ Newspaper ☐ Phone Book ☐ Website ☐ Clinic Sign ☐ Pharmacy ☐ Other

ALLERGIES: No known allergies: ☐

Local Anesthetics? (i.e.: Xylocaine, Novocaine) ☐ Y ☐ N Medications (i.e.: Penicillin, Sulfa) ☐ Y ☐ N

Adhesive tape/bandaids? ☐ Y ☐ N Environmental (i.e.: bees, trees): ☐ Y ☐ N

List Allergies: ________________________________________________________________________________

Cigarette/Tobacco Use: ☐ no ☐ previous use: # of year's _____ ☐ less than 1 pack/day ☐ more than 1 pack/day

| MEDICAL HISTORY | CHECK ALL THAT APPLY | Please list your current prescription medications/vitamins: |
|---|---|---|
| **Diabetes**: Yes __ No ___ Type 1 | Type 2 Diet Controlled | ______________________________ |
| Control Level: Poor Good | Great A1c Test:_________ | ______________________________ |
| ☐ Arthritis: ____________________ | | ______________________________ |
| ☐ Congestive Heart Failure | ☐ Heart Trouble: ___________ | ______________________________ |
| ☐ Blood Pressure | ☐ Lung Disease: ____________ | ______________________________ |
| ☐ Peripheral Vascular Disease | ☐ Cancer:__________________ | ______________________________ |
| ☐ Hepatitis A / B / C | ☐ Stroke (year): ___________ | ______________________________ |
| ☐ Thyroid Condition | ☐ Bleeding Disorders | ______________________________ |
| ☐ Multiple Sclerosis | ☐ Cholesterol | ______________________________ |
| ☐ Kidney Disease | ☐ Liver Disease | ______________________________ |
| ☐ Gout | ☐ HIV/AIDS | ______________________________ |
| ☐ Hearing Impaired | ☐ Vision Impaired | ______________________________ |
| ☐ Other: ___________________ | ☐ Skin Problem: ________________ | ______________________________ |
| | | ______________________________ |
| Do you take blood thinners? ☐ Y | ☐ N | ______________________________ |
| Are you slow to heal? ☐ Y | ☐ N | |

## HELP US HELP YOU! **Please answer the following questions.**

Does your foot problem involve: ☐ Right foot only ☐ Left foot only ☐ both feet

Explain your current foot problem(s):________________________________________________

________________________________________________________________________

Degree of Pain:

| 1 low | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 high |
|---|---|---|---|---|---|---|---|---|---|

Have you had medical treatment for this problem? ☐ Y ☐ N How long have you had this problem? ____________

What is your current: Height: ____________ Weight: _____________ Shoe Size: _______________

On the average, how many hours are you on your feet per day? 2-4hrs 4-6 hrs 6-8hrs 8-10hrs 10+ hrs

Occupation: ______________________________________________________________

Sports & Physical Activity: _______________________________________________________

What type of footwear do you wear most? ☐ Safety shoe/ boot ☐ Athletic ☐ Dress ☐ Sandal ☐ Other

Did you previously or are you currently wearing:

Over the counter inserts? ☐ Y ☐ N Are you still using them? ☐ Y ☐ N Did they help? ☐ Y ☐ N

Custom Made Orthotics? ☐ Y ☐ N Are you still using them? ☐ Y ☐ N Did they help? ☐ Y ☐ N

When did you get them? __________from (Practitioner) ___________________________________

**Do you have or have you been treated for: (check all that apply)**

| | | | |
|---|---|---|---|
| ☐ Back Pain | ☐ Gout | ☐ Warts | ☐ Heel Pain |
| ☐ Broken foot bones | ☐ Arch Pain | ☐ Ball of Foot Pain | ☐ Ankle Injury |
| ☐ Corns/ Callus | ☐ Neuroma | ☐ Knee Pain | ☐ Bunions |
| ☐ Ingrown Toenails | ☐ Hammer Toes | ☐ Childhood Foot Problems | ☐ Lower Back Pain |
| ☐ Gait/ Walking Problems | ☐ Open Wounds | ☐ Flat Feet | ☐ Other |

## PATIENT'S CONSENT: **(Please read & initial your consent on each line below)**

___ I hereby consent to examination and treatment by the Chiropodist.

___ I allow photographs of treatment areas to be taken for the purposes of monitoring and education.

___ I consent/allow the Chiropodist to contact and/or send my Physician or health care professional any pertinent information required regarding my foot exam and/or treatment plan or medical information.

___ I understand that in the event that the Chiropodist I normally see becomes unavailable for my appointment, I agree to see the attending Chiropodist for my treatment that day.

___ I understand that 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.

Patient's Signature): ______________________________Date: ______________________

Guardian Signature: ______________________________Relationship:__________________

Print Name of Guardian: ________________________________________________

*We promise to treat your personal information with respect. Our privacy protocols comply with privacy legislation, the standards of the College of Chiropodists of Ontario and the law. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.*