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: _____ Date of Birth: (month) _____ (day) ____ (year) _____

Address: _____City: _____

Postal Code: _____ Email: _____

Phone (home) #: _____ (cell) _____ (work) _____

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

Family Physician: _____ Address: _____

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

□ Physician Referral □ 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 Environnemental (i.e.: bees, trees): □ Y □ N

List Allergies: _____

MEDICAL HISTORY --CHECK ALL THAT APPLY AND LIST PRESCRIPTION MEDICATIONS BESIDE THE CONDITION			
□ **Diabetes- (Please circle) Type 1 / Type 2 / Diet Controlled**			
□ **Congestive Heart Failure**		□ **Blood Pressure**	
□ **Heart Trouble:_____**		□ **Cholesterol**	
□ **Peripheral Vascular Disease**		□ **Thyroid Condition**	
□ **Stroke (year): _____**		□ **Gout: _____**	
□ **Arthritis: _____**		□ **Cancer:_____**	
□ **Skin Problem: _____**		□ **Cerebral Palsy**	
□ **Kidney Disease**		□ **Hearing Impaired**	
□ **Lung Disease**		□ **Vision Impaired**	
□ **Liver Disease**		□ **Multiple Sclerosis**	
□ **Hepatitis A / B / C**		□ **HIV/AIDS**	
□ **Bleeding Disorders**		□ **Vitamins**	
□ **Do you take blood thinners? □ NO □ YES MEDICATION:**			
□ **Are you slow to heal? □ NO □ YES**			
□ **Cigarette/Tobacco Use: □ NO Number of year's_____ □less than 1pack/day □ more than 1pack/day**			
□ **CHECK IF ATTACHING A LIST OF MEDICATIONS**			

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) _____

PATIENT'S CONSENT: Please initial on each line below confirming you have read the consent

✓ I understand this clinic has several Chiropodists all focused on my treatment plan. I consent to treatment by the Chiropodist available at my appointment time which may differ from the original Chiropodist booked.

__ This is a zero tolerance office that strictly prohibits abusive language, aggressive behaviour, verbal abuse, bullying and sexual harassment. I understand that I will banned from the clinic if this behaviour is noted.

__ 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 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.

__ Simcoe Foot Care & Custom Orthotic Centre provides a paid service to remind you of your upcoming appointments however it is your responsibility to attend your appointment scheduled. I understand that in the event of missing my scheduled appointment without 24 hours' notice that I will be responsible for a missed appointment charge of $40.00.

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.