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				LIST MEDICATIONS & VITAMINS
	Diabetic: Type 1		**Diabetic: Type 2; Diet Control**	
	Congestive Heart Failure		**Arthritis:_____**	
	Heart Condition:_____		**Skin Problem:**	
	Peripheral Vascular Disease		**Thyroid Condition: _____**	
	Stroke (year): _____		**Gout**	
	Blood Pressure		**Cancer:_____**	
	Cholesterol		**Cerebral Palsy**	
	Kidney Disease		**Multiple Sclerosis**	
	Lung Disease		**Vision Impaired**	
	Liver Disease		**Hearing Impaired**	
	Hepatitis A / B / C		**HIV/AIDS**	
	Bleeding Disorder:_____		**Alzheimer's/Dementia**	
	Cognitive or Intellectual Disability:_____			
	Other:_____			
Do you take blood thinners? □ NO □ YES: LIST MEDICATION:				
Are you slow to heal? □ NO □ YES				
Do you currently smoke cigarettes?_____ if yes: Number of year's_____ How much daily_____				
□ 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 HIGH

Have you had medical treatment for this problem? □ Y □ N How long have you had this problem? _____

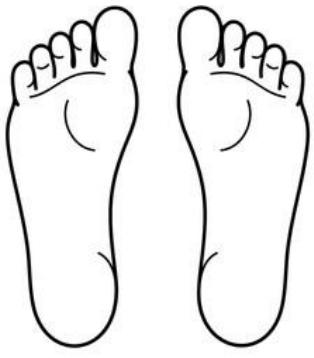
What is your current: Height: _____ Weight: _____ Shoe Size: _____

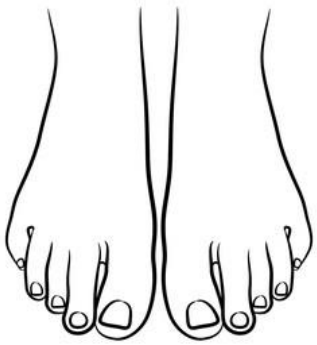
On the average, how many hours are you on your feet per day? 2-4hrs 4-6 hrs 6-8hrs 8-10hrs 10+ hrs

Occupation: _____ Sports & Physical Activity: _____

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

CHIROPODIST USE ONLY





CHIROPODIST NOTES:_____

_____

_____

_____

_____

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_____

_____

_____

PATIENT'S CONSENT: **Please initial in each box below confirming you have read the consent**

	Patient appointments are high in demand and vary in degree of time requirement and level of care. The attending Chiropodist will kindly advise you of your management plan that includes an appropriate time frame for rebooking. I consent to treatment by the Chiropodist available at my appointment time which may differ from the original Chiropodist booked and accept the best appointment availability provided by booking staff.
	This is a zero tolerance office that strictly prohibits verbal abuse and harassment, abusive language aggressive behavior, bullying and sexual harassment. I understand that I will banned from the clinic if this behavior 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. I understand that it is my responsibility to attend my scheduled appointment and in the event of missing the scheduled appointment without 24 hours' notice, 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.