25 Thickson Road North, Unit 4C, Whitby, ON, L1N 8W8
T: 905 436 2265 | E: info@fcoc.ca | www.fcoc.ca

CONTACT INFORMATION:

Date: _____

Last Name: _____ First Name: _____ Gender: _____

Address: _____ Unit/Apt/ # _____ City: _____

Province: _____ Postal Code: _____

Tel. Res.: _____ Tel. Cell: _____ Tel. Bus. _____
Please note: We do need at least 2 phone numbers in case of emergency

Date of Birth: _____/_____/_____ Age: _____
D M Y
Marital Status: O Single O Married O Widowed O Separated O Divorced O Common Law

Occupation: _____ Company: _____

Family Doctor's name: _____

Family Doctor's Address: _____

Do you consent to our clinic sending a report to your family doctor, if required? O Yes O No

Email*: _____

***I would like to receive the following via e-mail:**
O Notice when it is time to review my treatment plan
O Appointment reminders, newsletters and other informational mailings from The Footcare and Centre- Whitby

Signature: _____ Date: _____

INSURANCE INFORMATION:
Do you have any insurance or health benefits? O Yes O No

Insurance Company: _____ Policy#: _____ I.D.#_____

HOW DID YOU HEAR ABOUT OUR CLINIC?
Select all that apply**:**
O Yellow Pages O Internet O Website O Signage O Facebook O Other: _____

O Referring Physician_____ O Word of Mouth - *Who may we thank for your referral?* _____

THE FOOTCARE AND ORTHOTIC CENTRE Whitby

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MEDICAL HISTORY:

Do you suffer with:	YES	NO	Diagnosed (Month/Year)	**Please Specify:** Type, Past Treatment, Family History, Other Relevant Info.
Loss of hearing/vision problems/difficulty speaking/ dizziness				
Asthma / bronchitis / Emphysema:				
What triggers the attacks/ frequency/ severity				
Heart attack / angina / shortness of breath/ irregular heart beat				
High cholesterol				
Congestive heart failure				
Stroke				
Diabetes:				
Type I OR II				
Last blood sugar reading				
Numbness or tingling in hands or feet				
History of ulceration				
History of blood clots				
High blood pressure				
Osteoporosis				
Osteoarthritis				
Gout				
Rheumatoid arthritis				
Communicable diseases:				
Hepatitis				
HIV / AIDS				
Congenital/Genetic Conditions				
Thyroid problems				
Dermatological/ skin conditions (psoriasis, eczema, dermatitis, etc.)				
Mental Illness (anxiety, depression, bi-polar disorder, etc.)				
Nervous System disorders (seizures, epilepsy, etc.)				
Kidney Disease				
Liver problems				
Other:				

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MEDICAL HISTORY CONT.

Are you consulting any medical professionals for any ongoing medical issues?

_____

Have you seen any medical professionals regarding your feet in the past?

_____

Have you ever had any of the following in relation to your lower extremities (low back, hips, knees, ankles, feet, toes)?

	YES	NO	Month/Yea	Description/Limitations/Comments
Injuries / accidents				
Surgical procedures				
Fractures				

At birth, did you have any complications? Rotation of the foot or leg? _____

Did you begin to walk at a normal time? O Early O Normal (12-14 months) O Late *Please specify age if known* ____

Do you have any allergies? Please specify.

O No known drug allergies
O Foods _____
O Medications _____
O Environmental_____

List of Medications (prescription and non-prescription). Please include dosage and duration if you know.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you drink alcohol regularly? O Never O 1-3 per week O 4-9 per week O 10+ per week

Do you currently smoke? O No O Yes (amount per day) _____ O In the Past (amount per day) _____

Does your occupation involve: O Sitting O Standing O Walking O Heavy Lifting

Do you exercise regularly? O Never O 1-3 times per week O 3-5 times per week O 5+ times per week

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COMPLAINT:

What is the reason for your visit today?	How long have you had this concern for?	Grade Pain (10 = most severe)	Have you had any past treatment?	Is there any past history of injury in relation to this concern?
1.		/10		
2.		/10		
3.		/10		

Please describe your pain. Select all that apply.
O INTERMITTENT O CONTINUOUS O SHARP O SHOOTING O BURNING O DULL O ACHING
O THROBBING O OTHER: _____

Have you had any imaging, (x-ray, ultrasound, MRI, CAT Scan), performed in relation to your complaint today? Please describe.
Method: _____ Date: _____ Results: _____
Method: _____ Date: _____ Results: _____
Method: _____ Date: _____ Results: _____

FOOTWEAR HISTORY:

Please list your most current footwear.

Type (Runners, flats, safety footwear, sandals, etc.)	How long have you had these shoes for?

Have you ever worn orthotic insoles? _____ If yes, why? _____
How were they created? Please select all that apply:
O Computerized Gait Analysis O 3-D Scan O Plaster Cast O Foambox Impression O Not Sure

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Consent for Treatment and the Cost of Our Services

I hereby request and consent to Chiropody treatment. I give the Chiropodist permission to perform the necessary examinations, assessments and other Chiropody procedures, including but not limited to various modes of physical therapy, and photographs taken by the chiropodist and/or anyone working in this clinic authorized by the Chiropodist. I understand and am informed that, as in all health care, in the practice of Chiropody there are some very slight risks to treatment, including, but not limited to pain, swelling and infection. I do not expect the Chiropodist to be able to anticipate and explain all risks and complications and I wish to rely on the Chiropodist to exercise judgement during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known, is in my best interests.

Payment for any Chiropody visits are to be paid on the day of service. The initial visit fee of $70.00 is due upon day of consultation. Any fees for subsequent appointments will be discussed on the initial visit. Unpaid invoices are subject to a monthly surcharge of 15% after 30 days. _____ **(Initial).**

Consent for Personal Information

Privacy of personal information is an important principle to The Footcare and Orthotic Centre- Whitby. I understand that all of my personal information is confidential and will be used for no other purpose than for the Chiropodist's clinical records and to comply with legal and regulatory requirements of The College of Chiropodists of Ontario. We also try to be open and transparent as to how we handle personal information. If you have not yet been offered, please ask to review a copy of our Privacy Policy.

I understand that this consent form will cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I have been given the chance to ask any questions I have about The Footcare and Orthotic Centre- Whitby's policies, and they have been answered to my satisfaction. If at any time during the course of treatment, I wish to withdraw my consent, I may do so.

_____ _____ _____

Patient Signature* **Print Name** **Date**

**(Parent/Guardian must sign if patient is under the age of 16)*

Attendance Policy:

The Footcare And Orthotic Centre- Whitby is committed to providing you with the highest quality of care and treatment. In order to do this, we ask that all of our patients arrive on time for their appointments. Your appointment time is reserved exclusively for you. There will be no charge for appointment cancellations provided that two working days notice is given. The Footcare and Orthotic Centre- Whitby reserves the right to charge $25.00 for any missed appointments if the required two workings days' notice is not given. _____ **(Initial).**

I have read the above Attendance Policy and understand that my cooperation and active participation directly relates to my foot health.

_____ _____

Patient or Parent/Guardian Signature Date