Abbott Foot & Ankle Clinic

10126 Hwy. 26 East,Unit #3, Collingwood, Ontario L9Y 3Z1

Patient Information Form

Welcome to Abbott Foot & Ankle Clinic! We're dedicated to providing exceptional footcare for people of all ages. Please help us get to know you better by providing the following information:

First Name_____ Last Name _____

Address _____ City _____ Postal Code _____

Phone: (H) _____

(Cell) _____ (Business) _____

Date of Birth: D/_____M/_____Y/_____ Email: _____

How would you like your appointments confirmed? ❑ Email ❑ Phone

Your Occupation _____ Employer _____

Emergency Contact: _____ Relationship _____

Phone: _____

Parent/Guardian Names (if child is under 18): Mother: _____

Father: _____

How did you first hear about Abbott Foot & Ankle Clinic?

❑ Friend/family/colleague _____

(please indicate referrer's name so we may thank them)

❑ Internet ❑ Newspaper ❑ Health Care Professional

❑ Yellow Pages ❑ Other _____ (please specify)

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Help us help you! Please answer the following foot questions:

Your foot problems involve:

❑ Right Foot Only ❑ Left Foot Only

❑ Both Feet

Please explain your current foot problem(s):

_____

_____

Is this problem getting: worse ❑ better ❑ same ❑

Have you had medical treatment for this problem?

❑ Yes ❑ No

Have you had medical treatment for any of the below:

❑ Broken foot/leg bones ❑ Warts

❑ Heel Pain ❑ Flat feet

❑ High arch feet/pain ❑ Ankle injury

❑ Childhood Foot Problems ❑ Neuroma

❑ Callouses ❑ Knee Pain

❑ Hammertoes ❑ Corns

❑ Bunions ❑ Ingrown nails

❑ Back pain ❑ Gout

If you've had foot x-rays when were they taken? _____

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 footwear do you wear most for work or leisure?

❑ Safety Shoe/Boot ❑Athletic ❑ Dress

❑ Casual ❑ Other_____

Do you currently use othotics (shoe inserts)? ❑ Yes ❑ No

Check any sports/activities you participate in regularly:

❑ Hockey ❑Soccer ❑ Aerobic/Aqua fit

❑ Walking ❑ Running ❑ Golf

❑ Skiing ❑ Raquet Sports ❑ Other: _____

Continued on other side…

Do you have <u>or</u> have you ever been treated for:
(Check all that apply)

- ❑ Diabetes: Type 1 ❑ Type 2 ❑ How long: _____
- ❑ Heart Trouble
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Urinary Problems
- ❑ Stroke
- ❑ Depression
- ❑ High Blood Pressure
- ❑ Cholesterol
- ❑ Cancer
- ❑ Shortness of Breath
- ❑ Skin Disorder
- ❑ Thyroid Problem
- ❑ HIV/AIDS
- ❑ Blood Disease
- ❑ Stomach/Bowel Trouble
- ❑ Anxiety
- ❑ Bone Disease
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Tuberculosis
- ❑ Other: _____

Please list your current Rx Medications:

_____

_____

_____

_____

_____

Do you have any known allergies to:

Local anaesthetics? (e.g. Xylocaine, Novocaine) ❑ Yes ❑ No

Adhesive tape/band-aids? ❑ Yes ❑ No

Other: _____

_____

Are you slow to heal after cuts? ❑ Yes ❑ No

Do you bruise easily? ❑ Yes ❑ No

Are you currently pregnant or nursing? ❑ Yes ❑ No

Patient Physicians & Medical Specialists:

Family Physician: _____

Has your doctor treated your foot condition? ❑ Yes ❑ No

Did this doctor refer you to us? ❑ Yes ❑ No

Other Doctor's Name: _____

Type of Doctor: _____

. . . . . .

Patient's Consent:

- ❑ I hereby allow and consent to examination and treatment by the Chiropodist and allow photographs of treatment areas to be take for the purposes of monitoring.
- ❑ I consent /allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information.
- ❑ 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 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 provide consent to be contacted via email regarding clinic updates and promotions.

Patient's Signature (or guardian): X_____ Date: _____

<u>Cancellation Policy:</u>

Please call us at 705-444-9929 by 5:00 p.m. <u>two days</u> prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a *Monday* appointment, please call our office by 5:00 p.m. on *Thursday*. If prior notification is not given, you will be charged $30.00 for the missed appointment. X_____ **Patient's Initials**

Abbott Foot & Ankle Clinic promises 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 footcare.

Chiropodist's Signature: _____Date:_____