Abbott Foot & Ankle Clinic
3-10126 Hwy 26 East
Collingwood ON L9Y 0W3
(705)-444-9929

At Abbott Foot & Ankle Clinic we are committed to getting you back on your feet free of pain and injury so that you can get back to your activities and back into life! We understand that when your feet hurt, you hurt all over and you stop doing the things you love to do. We stop the pain and prevent the injuries that occur in people's feet, ankles, legs, knees, hips and backs by addressing the imbalances which most often begin in the feet! We feel your feet are your foundation and a strong foundation is our goal. We thank you for the opportunity to serve you and give you the results you are looking for. Sincerely,

Tony Abbott, D.Ch.

☐ Mr. ☐ Dr. Today's Date: _____
☐ Mrs. _____
☐ Miss. Last Name First Name MI. DOB: D/_____M/_____Y/_____

Height: _____ Weight: _____ Shoe Size: _____

Address: _____ Home Phone #: (_____) _____-_____

City: _____ Postal Code: _____

Cell Phone #: (____) _____-_____ E-mail address _____

In case of emergency, notify: _____ Relationship: _____

Home Phone: (____) _____-_____ Business Phone: (_____) _____-_____ Cell: (____) _____-_____

Occupation: _____ If retired, your former occupation: _____

Patient's Employer: _____

Extended Health Care Insurance Provider:

Member Name _____ Member ID_____

Provider Name _____ Policy #_____

Are any of your friends, relatives or associates our patient? ☐ Yes ☐ No If Yes, who?_____

If under 18 y/o, parent/guardian: _____Relationship to Patient: _____

Whom may we thank for your referral? _____

How did you here about our practice? _____

If you used the internet to find us, what search terms were used? _____

_____

Primary Physician: _____

Medical History

1. How is your general health? □ Good □ Fair □ Poor
2. Are you now, or within the past two years, under a physician's care? □ Yes □ No If yes, what are you being treated for:

   _____

   _____
3. Do you take prescribed and/or over the counter medicine? □ Yes □ No
   If yes, what medications are you taking? (Please list or provide a copy of list): _____

   _____

   _____

   _____
4. Are you allergic to any medicines, adhesive tape, latex or penicillin? □ Yes □ No
5. Are you allergic to local anesthetic? □ Yes □ No
   Other allergies**:** _____

   _____
6. Do you have now, or have you ever had any of the following:

□ Diabetes	□ Liver Problems	□ Growing Pains
□ Kidney Trouble	□ Hepatitis	□ Arthritis
□ Heart Trouble	□ HIV / ARC	□ Gout
□ High Blood Pressure	□ Cancer	□ Foot Ulcers
□ Anemia	□ Skin Cancer	□ Phlebitis
□ Asthma	□ Melanoma	□ Numbness in feet or legs
□ Blood Diseases	□ Epilepsy	□ Cramps in feet or legs
□ Rheumatic Fever	□ Circulation Disease	□ Broken Bones in Leg
□ Raynaud's Disease	□ Stomach Ulcers	□ Broken Bones in Feet
□ Thyroid Condition	□ Eye Problems	□ Other _____

7. Is there a family history of Diabetes? □ Yes □ No Insulin Dependant? □ Yes □ No
8. Have you had any surgeries? □ Yes □ No [If yes, **Please list below:]**

Approx. Month & Year	**Surgical Procedures and / or Traumatic Injuries**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your primary foot concern? _____

1. **Do you have any FOOT pain?** □ Yes □ No □ Right □ Left □ Both
   If yes, Please explain: _____

   _____

   For How long? _____

Previous treatment for this pain / problem? □ Yes □ No
If yes, Please explain: _____
_____
Does anything make it □ better or □ worse?_____
_____

2. **Do you have any KNEE pain?** □ Yes □ No □ Right □ Left □ Both
If yes, Please explain: _____
_____
For How long? _____
Previous treatment for this problem? _____ □ Yes □ No
Please explain: _____
_____
Does anything make it □ better or □ worse?_____
_____

3. **Do you have any HIP pain?** □ Yes □ No □ Right □ Left □ Both
If yes, Please explain: _____
_____
For How long? _____
Previous treatment for this problem? _____ □ Yes □ No
If yes, Please explain: _____
_____
Does anything make it □ better or □ worse?_____
_____

4. **Do you have any Back pain?** □ Yes □ No □ Upper Back □ Lower Back □ Neck
If yes, Please explain: _____
_____
For How long? _____
Previous treatment for this problem? _____ □ Yes □ No
If yes, Please explain: _____
_____
Does anything make it □ better or □ worse?_____
_____

5. **Do you have any leg cramps or pain?** □ Yes □ No / □ Right □ Left □ Both
If yes, Please explain: (include Frequency)_____
_____
_____
How long has this been going on? _____
Previous treatment for this problem?_____ □ Yes □ No
If yes, Please explain: _____
_____
Does anything make it □ better or □ worse?_____
_____

6. **Do any of the above problems limit your ability to walk?** □ Yes □ No
_____
_____ **to stand?** □ Yes □ No _____
_____ **to wear shoes?** □ Yes □ No _____
_____ **to work?** □ Yes □ No _____
_____ **to partake in social or sporting activities?** □ Yes □ No _____

7. **Do you currently wear or have you ever worn Orthotics (arch supports)?** □ Yes □ No **If yes**, were they prescribed to you by a physician or health care provider □ Yes □ No
If yes, were they the over the counter style bought from a store □ Yes □ No
If yes, did you find that they helped you to any significant degree □ Yes □ No

8. **If you are a runner or athlete please tell us about your sport. Include recent history, weekly mileage breakdown, frequency or times and if you are currently training for any event.**
_____
_____
_____

9. **What type of Shoes do you wear and how often do you wear them? Please Circle or cross out**

MALE

□ Sneakers / Tennis Shoes _____ % of time □ Lace Up Dress Shoes _____ % of time □ Casual Shoes _____ % of time □ Loafers or Deck Shoes _____ % of time □ Pumps or Low Heel Open Shoes _____ % of time
□ Work Boots or Other Boots _____ % of time
□ Flip Flops or Sandals _____ % of time

FEMALE

□ Sneakers / Tennis Shoes _____ % of time
□ High Heel Shoes (2 inch or greater) _____ % of time
□ Work Boots or Other Boots _____ % of time
□ Flip Flops or Sandals _____ % of time

10. **When you're at home, what is on your feet?**
□ Regular Shoes _____ % of time □ Slippers _____ % of time □ Bare Feet _____ % of time

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Patient Name: _____

This is the most important part of this paperwork.

11. In the last few months has there been a recent change in your:

☐ Weight ☐ Work ☐ Activity ☐ Shoe Gear ☐ Flooring at work or home **Please explain**:

_____

_____

Please tell us what are your Goals and Expectations relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your visit today?** _____

_____

_____

_____

_____

_____

Relating to your specific complaint(s), what would you like to be able to accomplish **in the near future** that you may not be able to do right at this moment? **(please include intermediate and long term goals)** _____

_____

_____

_____

_____

_____

I understand that any follow-up appointments I make are crucial to my treatment and the success of my care. During these appointments, the chiropodist / staff will give me the necessary attention. Please keep all appointments or call to change an appointment with 24 hours notice.

Patient/ Guardian Print: _____ Date: _____

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Patient Consent / Privacy and Cancellation Policy Patient

Consent:

□ I herby allow and consent to examination and treatment by the Chiropodist and allow photographs of treatment areas to be taken for the purpose 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 the service is provided. OHIP does not cover the fees

□ I provide consent to contacted via email regarding clinic update / promotions.

Parent / Guardian Signature: _____ Date: _____

Privacy Policy:

Here is a summary of our privacy policies, which outline what our office is doing to ensure that:

- only necessary information is collected about you
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols

By signing the Abbott Foot & Ankle Clinic Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Parent / Guardian Signature: _____ Date: _____

Cancellation Policy:

We require 24 hours notification for cancellation of an appointment, or a fee of $40 will be charged for your missed appointment or last minute cancellation. Exceptions will made for extreme weather conditions or special circumstances.

Parent / Guardian Signature: _____ Date: _____