

New On-Line Form – For your convenience this document can be completed on your computer. Simply complete the form and save to your desktop, then email to - stouffvillefootcare@bellnet.ca

Please help us get to know you better by providing the following information:

First Name _____ Last Name _____

Address _____ City _____ Postal Code _____

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

Date of Birth (D/M/Y) _____ Email address _____

Would you like us to confirm your appointments by Email: Yes No Phone: Yes No

Your Occupation _____ Employer _____

Emergency Contact: _____ Relationship: _____

Phone: _____

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

How did you first hear about Stouffville Family Footcare?

Friend/family/colleague _____

Internet Newspaper Health Care Professional

Yellow pages Other _____

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

Your foot problems involve:

Right Foot Only Left Foot Only

Both Feet

Why are you here today, explain your current foot problem(s):

Is this problem getting: Worse Better Same? (check one)

Have you had medical treatment for this problem? Yes No

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 Sandal

Other _____

Do you currently use orthotics (shoe inserts)? _____

Have you ever been treated for: (check all that apply)

<input type="checkbox"/> Back pain	<input type="checkbox"/> Gout
<input type="checkbox"/> Warts	<input type="checkbox"/> Broken foot/leg bones
<input type="checkbox"/> Heel pain	<input type="checkbox"/> Flat feet
<input type="checkbox"/> High arch feet/pain	<input type="checkbox"/> Ankle injury
<input type="checkbox"/> Corns	<input type="checkbox"/> Neuroma
<input type="checkbox"/> Callouses	<input type="checkbox"/> Knee pain
<input type="checkbox"/> Bunions	<input type="checkbox"/> Ingrown nails
<input type="checkbox"/> Hammertoes	<input type="checkbox"/> Childhood Foot Problems

Check any sports or activities you participate in regularly:

<input type="checkbox"/> Walking	<input type="checkbox"/> Running
<input type="checkbox"/> Aerobics/Aqua	<input type="checkbox"/> Fit Golf
<input type="checkbox"/> Hockey	<input type="checkbox"/> Soccer
<input type="checkbox"/> Racquet Sports	<input type="checkbox"/> Skiing
<input type="checkbox"/> Other: _____	

Please answer the following questions:

Do you have or have you ever been treated for:

(Check all that apply)

- Diabetes: Type 1 Type 2 How Long? _____
- | | |
|--|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Urinary Problem | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach/Bowel Trouble |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Disease |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> None Apply Other: _____ | |

Please list your current Rx medications:

- Do you have any known allergies to:
- Local anesthetics? (e.g. Xylocaine, Novocaine) Yes No
- Adhesive tape/band-aids? Yes No
- No allergies known: 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:

FamilyPhysician: _____
Phone: _____

Has your doctor treated your foot condition? Yes No

Other Doctor's Name: _____

Type of Doctor _____

Phone: _____

Did this doctor refer you to us? Yes No

Patient's Consent:

- I hereby allow and consent to examination and treatment by the Chiroprapist and allow photographs of treatment areas to be taken for the purposes of monitoring.
- I consent/allow the Chiroprapist to contact my physician for any pertinent information required relating to my treatment or medical information.
- I consent/allow the Chiroprapist 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.

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

Stouffville Family Foot Care promises to treat your personal information with respect. Our privacy protocols comply with privacy legislation, the standards of the College of Chiroprapists of Ontario and the law. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.

Chiroprapist's Signature: _____ **Date:** _____