

J. Richard Werkman, D.Ch., B.Sc. Podiatric Medicine

Oakville Foot & Orthotic Specialist - Exceptional footcare for all ages

PATIENT INFORMATION FORM

Welcome! 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: Home _____ Cell _____

Work _____ Other _____

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

We would also like to learn about your preferences for receiving information from us! Our clinic takes patient confidentiality seriously. We respect your privacy. Your information is safe and secure with us.

May we use your email address for Financial documents Appointment related Correspondence Newsletters/Other

Your Occupation _____ Employer _____

Emergency Contact _____ Relationship _____

Phone: _____

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

How did you first hear about our office?

Friend/family/colleague _____

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

Internet Newspaper Health care professional

Yellow pages Gold Book Other _____ (please specify)

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? **(Circle one)**

Have you had medical treatment for this problem? Y N

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 |

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)? _____

Check any sports or activities you participate in regularly:

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

Continued on other side ...

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? _____
- Heart Trouble Skin Disorder
- Hepatitis Thyroid Problem
- Liver Disease HIV/AIDS
- Urinary Problem Blood Disease
- Stroke Stomach/Bowel Trouble
- Depression Anxiety
- High Blood Pressure Bone Disease
- Cholesterol Arthritis
- Cancer Epilepsy
- Shortness of Breath Tuberculosis
- None Apply Other: _____

Please list your current prescription medications:

Do you have any known allergies to:

- Local anesthetics? (e.g. Xylocaine, Novocaine) Y N
- Adhesive tape/band-aids? Y N
- Allergies known: Y N

Other: _____

- Are you slow to heal after cuts? Y N
- Do you bruise easily? Y N
- Are you currently pregnant or nursing? Y N

Patient Physicians & Medical Specialists:

Family Physician: _____

Phone: _____

Has your doctor treated your foot condition? Y N

Other Doctor's name: _____

Type of Doctor _____

Phone: _____

Did this doctor refer you to us? Y N

Patient's Consent:

- I hereby consent to examination and treatment by the Chiropodist and/or support staff, also to allow photographs of treatment areas to be taken 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 hereby request and consent to the performance of a chiropody examination and other chiropody procedures, including various modes of palliative care, physical, surgical and orthotic therapy and, if necessary, diagnostic x-rays, on me by the Chiropodist named below and/or anyone working in this clinic authorized by the Chiropodist named below.
- I further 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, post-op infections. I do not expect the Chiropodist to be able to anticipate and explain all the risks and complications. I wish to rely on the Chiropodist to exercise judgment during the course of the procedure which the Chiropodist feels at the time, based upon the facts then know, is in my best interests.
- 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: _____

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 footcare.

Chiropodist's Signature: _____ Date: _____

J.Richard Werkman, D.Ch., B.Sc. Podiatric Medicine