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: (H)______________________

(Cell)______________________ (Business)______________________

Date of Birth (D/M/Y)____________Email address______________________

May we contact you by email to confirm your appointments or provide additional information: ❑ 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 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)

❑ Back pain ❑ Gout
❑ Warts ❑ Broken foot/leg bones
❑ Heel pain ❑ Flat feet
❑ High arch feet/pain ❑ Ankle injury
❑ Corns ❑ Neuroma
❑ Callouses ❑ Knee pain
❑ Bunions ❑ Ingrown nails
❑ Hammertoes ❑ 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:

❑ Walking ❑ Running
❑ Aerobics/Aqua Fit ❑ Golf
❑ Hockey ❑ Soccer
❑ Racquet Sports ❑ Skiing
❑ 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
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Urinary Problem
- ❑ Stroke
- ❑ Depression
- ❑ High Blood Pressure
- ❑ Cholesterol
- ❑ Cancer
- ❑ Shortness of Breath
- ❑ None Apply
- ❑ Skin Disorder
- ❑ Thyroid Problem
- ❑ HIV/AIDS
- ❑ Blood Disease
- ❑ Stomach/Bowel Trouble
- ❑ Anxiety
- ❑ Bone Disease
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Tuberculosis
- ❑ 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