J.Richard Werkman, D.Ch., B.Sc. Podiatric Medicine - Registered Chiropodist
Kaitlin V. Werkman, B.Sc. (Hons) Podiatry, MSc Diabetes - Registered Chiropodist
Werkman Foot & Orthotic Clinic - 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. Patients with serious medical emergencies should go to the nearest Hospital Emergency Department.

First Name__________________ Last Name __________________

Address__________________ City__________________ Postal Code__________________

Phone (Home)__________________ Cell__________________

Phone (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 ❑ Facebook
❑ LinkedIn ❑ Yellow pages ❑ 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
- ❑ Warts
- ❑ Heel pain
- ❑ High arch feet/pain
- ❑ Corns
- ❑ Callouses
- ❑ Bunions
- ❑ Hammertoes
- ❑ Gout
- ❑ Broken foot/leg bones
- ❑ Flat feet
- ❑ Ankle injury
- ❑ Neuroma
- ❑ Knee pain
- ❑ Ingrown nails
- ❑ 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
- ❑ Aerobics/Aqua Fit
- ❑ Hockey
- ❑ Racquet Sports
- ❑ Other: __________________
- ❑ Running
- ❑ Golf
- ❑ Soccer
- ❑ Skiing

Continued on other side ...

Please answer the following questions:
Do you have or have you ever been treated for:

(Check all that apply)

- ❑ Heart Trouble
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Urinary Problem
- ❑ 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
- ❑ Diabetes: Type 1 Type 2 How Long? ______________
- ❑ Have you ever attended a Diabetic Clinic? Yes / No
- ❑ Have you ever had a diabetic foot ulcer or infection? Yes / No
- ❑ Other: ____

Please provide your medication record or 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

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: Please refer to our website for additional information and Patient Policies

❑ I hereby consent/allow to examination and treatment including various modes of physical therapy, 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 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 pain, swelling and infection. 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's judgment in regards to my appointment and my care.

❑ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not and 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.

We require at least 24 hours' notice to cancel or reschedule an appointment. A $10 fee will be applied for appointments cancelled with less than 24 hours' notice, and a $20 fee will be applied for missed appointments. All fees for cancellations/missed appointments are the patient's responsibility.

Chiropodist's Signature: ____ Date: ________________________

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