OTTAWA FOOT & ANKLE CLINIC

CHIROPODY

Patient Intake Form and Informed Consent

First Name: _____ Last Name:_____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Alt Phone:_____

Date of Birth (mm/dd/yyyy)_____ email: _____

Sex: **M** / **F** Physician: _____

Height: _____ Weight: _____ Referred by: _____

Occupation: _____ Reason for your visit: _____

Footwear: _____ _____

Do you wear orthotics: **Y** / **N** _____

How did you hear about our office? _____

Medical History

Diabetes Mellitus: Type I ☐ Type II ☐ Since when? _____

Arthritis: Osteo ☐ Rheumatoid ☐ Other ☐ Since when? _____

Cardiovascular: High Blood Pressure ☐ Low Blood Pressure ☐

High Cholesterol ☐ Heart Attack ☐ Stroke ☐ Angina ☐

Varicose Veins ☐ Bleeding Disorders ☐ Other ☐

Respiratory: Asthma ☐ COPD: ☐ Other ☐

Kidneys, Liver or Thyroid :_____

Auto-Immune Disorders: _____

Fractures: _____

Surgeries: _____

_____

Cancer: _____

Other Medical Problems: _____

Smoking Y / N ☐ pack(s)/day **Alcohol Y / N** ☐ glasses/day

Recreational drugs Y / N _____

Medications (including over-the-counter): _____

_____

_____

_____

_____

_____

Allergies: _____

_____

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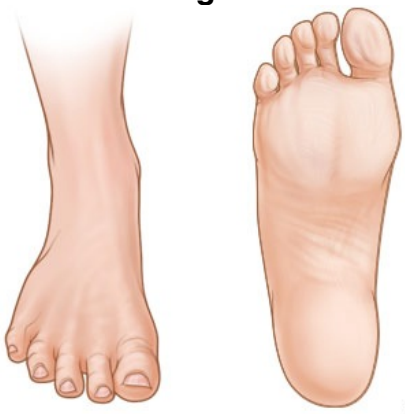
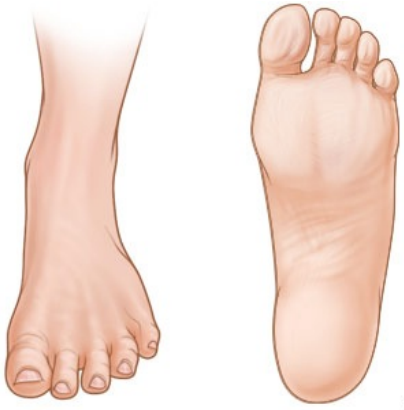
On these pictures, mark the area of your foot where the problem is.

Right Foot



Left Foot



Notes: _____

_____

Consent to Treatment

I understand the the Chiropodist is providing foot assessments and treatments within the scope of practice as defined by the College of Chiropodists of Ontario. I hereby consent to my Chiropodist to treat me within the scope of practice. I allow photographs of my feet to be taken for monitoring and education purposes.

I authorize release of any medical information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, as well as other data pertinent to my treatment, by Octavia Hristea, registered chiropodist, to my physician(s) or other health care providers currently involved in my care.

I understand that I am financially responsible for all charges, whether covered by my extended insurance plan or not. I understand that chiropody service fees are payable at the time of the appointment. I acknowledge that custom made/ordered devices are not refundable.

Cancellation Policy

We try to provide exceptional service to our patients. To help us achieve this, we ask that you provide us with at least 24 business hours notice if you need to reschedule or cancel your appointment, otherwise a 40$ no show fee will apply. Thank you for your consideration.

Signed _____ **Date:** _____

Patient or Guardian MM/DD/YYYY