AZILDA FAMILY FOOT CARE

WELCOME to Azilda Family Foot Care. Please take a few moments to fill out the following information:

Name_____ Birth Date_____
First Last MM/DD/YYYY

Gender_____ Marital Status_____ Primary Language_____

Mailing Address _____ _____ _____ _____ _____
Street Apt. P.O. Box City Postal Code

☐Home (____) _____ ☐Work (____) _____ ☐Cell (____) _____

Please check the box for your preferred number

Email _____ ☐ I provide consent to receive emails

Occupation _____ Company Name _____

Shoe Size _____ Weight _____ lbs

Are you covered under any of the following insurances?

☐ WSIB ☐ NIHB ☐ ODSP ☐ Veterans Affairs (Blue Cross)

ABOUT YOUR VISIT

1) How did you hear about this clinic? Please select all that apply:

   ☐ Website ☐ Facebook ☐ Signs ☐ Yellow Page ☐ Radio ad ☐ Flyer

   ☐ Doctor Referral (Name) _____ ☐ Spa (Name) _____

   ☐ Friend or Family (Who may we thank for the referral?) _____

   ☐ Other (Specify) _____

2) Do you have a family doctor?

   ☐ Yes (Name) _____ ☐ No

   Doctor's Location/Address_____

   Do you consent to our clinic sending a report to your family doctor if requires? ☐ Yes ☐ No

3) Have you had previous Chiropody/foot care?

   ☐ Yes (Where) _____ ☐ No

4) What is the reason for your visit today? Onset Date _____

☐ Nail Care ☐ Corn/Callus ☐ Wart ☐ Diabetic Foot Care

☐ Orthopedic/Custom Shoes ☐ Foot Pain ☐ Custom Orthotics/Insoles

☐ Knee/Hip/Back Pain ☐ Assessment ☐ Other _____

5) What are your expectations with the visit today? _____

_____

NOTE: Privacy of personal information is an important principle to Azilda Family Foot Care. We are committed to collecting, using, and disclosing personal information responsibly, and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. If you have not yet been offered, please ask to review a copy of our Privacy Policy. If required for your case, we will be in contact with your Family Physician.

MEDICAL INFORMATION

The answers to this medical questionnaire help us identify the cause of your foot problems. All information is confidential.

1) Do you consider yourself to be in good health? ☐ Yes ☐ No

2) Do you consider yourself to be a good healer? ☐ Yes ☐ No

3) Do you have any problems with your immune system? ☐ Yes ☐ No

4) Are you taking any prescribed medication? ☐ Yes ☐ No
(Please List) _____
_____
_____

5) Do you take any supplements? ☐ Yes ☐ No
(Please List) _____
_____

6) Do you have any allergies? ☐ Yes ☐ No
(Please List) _____
_____

7) a) Have you ever had local anesthetic (freezing) at the dentist or doctor? ☐ Yes ☐ No

b) If yes, have you ever had any allergic reaction to the anesthetic? ☐ Yes ☐ No

8) Do you need to take antibiotics before going to the dentist? ☐ Yes ☐ No

9) Have you ever had rheumatic fever as a child or an adult? ☐ Yes ☐ No

10) Do you smoke? ☐ Yes ☐ No
If yes, how many do you smoke per day? _____

11) Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per week? _____

12) Do you wear footwear in the house? ☐ Yes ☐ No

If yes, what type? _____

13) How would you rate your level of activity? ☐ Low ☐ Moderate ☐ High

FAMILY HISTORY

Please check any of the following disease or conditions that immediate members of your family have had:

☐ Heart Disease	☐ Stroke	☐ High Blood Pressure	☐ Diabetes
☐ Vascular Disease	☐ Asthma	☐ Cancer	☐ Obstructive lung disease
☐ Psoriasis	☐ Eczema	☐ Flat Feet	☐ Bunions

☐ Other _____

PERSONAL HISTORY

Please fill out the following questions as honestly and as accurately as possible:

1) Have you ever been admitted to or had surgeries in the hospital? ☐ Yes ☐ No

If yes, what were the reasons and dates: _____

_____

_____

_____

_____

2) Do you have diabetes? ☐ Yes ☐ No

If yes, please answer the following

☐ Type I ☐ Type II

When were you diagnosed with diabetes? _____

Do you check your blood sugar? ☐ Yes ☐ No How often? _____

What is your blood sugar range? _____

Have you ever had a diabetic foot ulcer or infection? ☐ Yes ☐ No

Have you attended a diabetic clinic? ☐ Yes ☐ No

Do you suffer from diabetic neuropathy? ☐ Yes ☐ No

3) Please check if you have or have a history of any of the following conditions:

☐ Head Injury	☐ Migraines/Headaches	☐ Stroke
☐ Nervous System Problems	☐ Epilepsy	☐ Seizures
☐ Parkinson's disease	☐ Cerebral Palsy	☐ Muscular Dystrophy
☐ High Cholesterol	☐ Heart Condition	☐ High Blood Pressure

☐ MRSA ☐ C. Difficile ☐ VRE

☐ Cramps ☐ Muscle Weakness ☐ Tingling in Legs or Feet

☐ Numbness ☐ Tuberculosis ☐ Osteoporosis

☐ Arthritis ☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Gout ☐ Fibromyalgia ☐ Sciatica

☐ Hives/Rashes ☐ Eczema/Psoriasis ☐ Hypo/Hyperthyroidism

☐ Anxiety ☐ Insomnia ☐ Depression

☐ COPD ☐ Emphysema ☐ Asthma

☐ Cancer

If yes, when and what kind: _____

☐ Heart Attack

If yes, when: _____

4) a) Do you have or have you been treated for Varicose Veins? ☐ Yes ☐ No

If yes, when: _____

b) Have you worn or do you currently wear compression stockings? ☐ Yes ☐ No

5) Do you have or have you had poor circulation? ☐ Yes ☐ No

If yes, does it affect your legs/feet? ☐ Yes ☐ No

6) Have you ever had any of the following blood problems?

☐ Anemia ☐ Prolonged Bleeding

☐ Hepatitis A, B or C ☐ HIV ☐ Other: _____

7) Please check if you have or have had any problems with any of the following:

☐ Eyes ☐ Ears ☐ Nose

☐ Throat ☐ Liver ☐ Bladder

☐ Kidney ☐ Stomach ☐ Back

EMERGENCY CONTACT

1) Name: _____
Home phone: _____
Cell phone: _____

2) Name: _____
Home phone: _____
Cell phone: _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropody treatment or other chiropody procedures, including various modes of physical therapy by the chiropodist and/or anyone working in this clinic authorized by the chiropodist.

I further understand and am informed that, as in all health care, in the practice of chiropody there are some 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 risks and complications and I wish to rely on the chiropodist to exercise good judgements during the course of the procedure which the chiropodist feels at the time, based upon the facts then known, and is in my best interest.

I have read the above and consent. By signing below I agree to above named procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. If at any time during the course of treatment I wish to withdraw my consent, I may do so.

To be completed by the patient or guardian prior to treatment:

Patient:_____

Guardian (if applicable): _____

Signature: _____

Date: _____

CANCELLATIONS AND MISSED APPOINTMENTS

At Azilda Family Foot Care, we understand that sometimes events happen that could lead you to reschedule, postpone or cancel your appointment. Please understand that such changes can affect not only your personal health but that of other patients' as well.

We ask that our patients provide a minimum 24 hour notice for any cancellation or changes to your booked appointment. Any changes or cancellations made to appointments without 24 hour notice may be subject to a cancellation fee.

I have read and understand the above policy: _____

Patient Signature