AZILDA FAMILY
FOOT CARE

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

Personal Information

Name _____ Birth Date _____
First Last MM/DD/YYYY

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

Phone _____
(Indicate preferred method of contact) ☐ Home ☐ Cell ☐ Work

Email _____ Occupation _____

☐ I provide consent to receive emails

Marital Status _____ Company Name _____

Primary Language _____ Gender ☐ M ☐ F

Shoe Size _____ Weight (lbs) _____

Are you covered by any of the following insurances? ☐ WSIB ☐ ODSP ☐ NHIB ☐ Veterans Affairs (Blue Cross)

About Your Visit

1. How did you hear about us?
Check all that apply

☐ Website
☐ Facebook
☐ Yellow Pages
☐ Radio Ad
☐ Signs
☐ Flyer
☐ Billboard
☐ Spa (Name) _____
☐ Doctor Referral (Name) _____
☐ Friend or Family (Who should we thank?) _____
☐ Other (Specify) _____

2. Do you have a family doctor? ☐ No ☐ Yes

Physician's Name _____

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

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

3. Have you had previous Chiropody/foot care? ☐ No ☐ Yes
If yes, where? _____

4. What is the reason for your visit today? Onset Date_____

☐ Nail Care ☐ Orthopedic/Custom Shoes ☐ Assessment ☐ Foot Pain
☐ Corn/Callus ☐ Custom Orthotics/Insoles ☐ Knee/Hip/Back Pain ☐ Wart
☐ Other (Specify)_____ ☐ Diabetic Foot Care

5. What are you expectations with today's visit?

_____

_____

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? ☐ No ☐ Yes
2. Do you consider yourself to be a good healer? ☐ No ☐ Yes
3. Do you have any problems with your immune system? ☐ No ☐ Yes
4. Are you taking any supplements? (Please List) ☐ No ☐ Yes

_____

_____

_____

5. Are you taking any prescribed medication? (Please List) ☐ No ☐ Yes

_____

_____

_____

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

_____

_____

7. Have you ever had local anesthetic (freezing) at the dentist or doctor? ☐ No ☐ Yes
8. If yes, have you had any adverse reactions to anesthetic? ☐ No ☐ Yes
9. Do you need to take antibiotics before going to the dentist? ☐ No ☐ Yes
10. Have you ever had rheumatic fever as a child or an adult? ☐ No ☐ Yes
11. How would you rate your level of activity? ☐ Low ☐ Moderate ☐ High
12. Do you smoke? If yes, how much do you smoke per day?_____ ☐ No ☐ Yes
13. Do you drink alcohol? If yes, how many drinks per week?_____ ☐ No ☐ Yes
14. Do you wear footwear in the house? If yes, what type?_____ ☐ No ☐ Yes

Family History

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

☐ Heart Disease	☐ Eczema	☐ Diabetes	☐ Stroke
☐ Vascular Disease	☐ High Blood Pressure	☐ Obstructive Lung Disease	☐ Asthma
☐ Psoriasis	☐ Cancer	☐ Bunions	☐ Flat feet

☐ Other (Specify)_____

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? ☐ No ☐ Yes
(Please Indicate When and Why)

_____

_____

_____

2. Do you have diabetes?

☐ No ☐ Yes

If yes, please answer the following

☐ Type I ☐ Type II

When were you diagnosed with diabetes? (MM/DD/YYYY)_____ ☐ No ☐ Yes
Do you monitor your blood sugar? If yes, how often?_____ ☐ No ☐ Yes
What is your blood sugar range?_____
Have you ever had a diabetic foot ulcer or infection? ☐ No ☐ Yes
Have you attended a diabetic clinic? ☐ No ☐ Yes
Do you suffer from diabetic neuropathy? ☐ No ☐ Yes

3. Please indicate if you have or have a history of any of the following conditions:

☐ Head Injury	☐ Migraines/Headaches	☐ Stroke	☐ Hive/Rashes
☐ Nervous System Problems	☐ Epilepsy	☐ Seizures	☐ Anxiety
☐ Parkinson's Disease	☐ Cerebral Palsy	☐ Muscular Dystrophy	☐ COPD
☐ High Cholesterol	☐ Heart Condition	☐ High Blood Pressure	☐ VRE
☐ MRSA	☐ C. Difficile	☐ Tingling in Legs or Feet	☐ Eczema/Psoriasis
☐ Cramps	☐ Muscle Weakness	☐ Osteoporosis	☐ Insomnia
☐ Numbness	☐ Tuberculosis	☐ Rheumatoid Arthritis	☐ Emphysema
☐ Athritis	☐ Osteoarthritis	☐ Sciatica	☐ Hypo/Hyperthyroidism
☐ Gout	☐ Asthma	☐ Fibromyalgia	☐ Depression

☐ Cancer (If yes, what type?)_____
☐ Heart attack (If yes, when?)_____

4. Do you have or have you been treated for Varicose Veins? ☐ No ☐ Yes
If yes, when? (MM/DD/YYYY)_____
Have you worn or do you currently wear compression stockings? ☐ No ☐ Yes

5. Do you have or have you had poor circulation? ☐ No ☐ Yes
If yes, does it affect your legs or feet? ☐ No ☐ Yes

6. Please indicate if you've had any of the following blood problems:

☐ Anemia ☐ Prolonged Bleeding ☐ Hepatitis A, B or C ☐ HIV
☐ Other (Specify)_____

7. Please indicate if you have had any problems with any of the following:

☐ Eyes ☐ Ears ☐ Stomach ☐ Bladder
☐ Throat ☐ Liver ☐ Nose ☐ Back
☐ Kidney

Emergency Contacts

Please indicate who we can contact in case of emergency:

1st Contact Name _____ 2nd Contact Name _____

Phone Number _____ Phone Number _____

Relation _____ Relation _____

Informed Consent

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

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 judgments 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. I understand this form covers 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.

Patient Name _____

Guardian (if applicable) _____

Signature _____ Date (MM/DD/YYY) _____

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 48 hour notice for any cancellation or changes to your booked appointment. Any changes or cancellations made to appointments without 48 hour notice may be subject to a cancellation fee.

I have read and understand the above policy: _____
Patient Signature