WELCOME TO WHITBY FAMILY FOOTCARE CLINIC

CHIROPODY FEES ARE NOT COVERED BY OHIP

The answers to the questions listed below will help us identify the cause of your foot problem and put together the best treatment plan for your foot problem.
Please answer the following questions:

PLEASE PRINT CLEARLY

NAME: _____ BIRTH DATE: _____

FIRST LAST MONTH DAY YEAR

FULL ADDRESS: _____

HOME PHONE: (___)_____ BUS**. PHONE: (___)**_____

E MAIL ADDRESS _____**@**_____

How did you find out about this clinic?
☐ Family Physician ☐Yellow Pages ☐Location ☐ Sign ☐ Word of Mouth ☐ Friend ☐Flyer
Other_____

What is your job?
☐ Retired ☐Construction ☐Factory ☐Auto worker ☐Farming ☐ Healthcare ☐Homemaker ☐Office
☐ Professional ☐Retail ☐Self employed ☐Service ☐Student ☐Other_____

Do you have extended insurance? ☐Yes ☐No Insurance **Company:**_____

Do you have a family doctor? ☐Yes ☐ No Dr._____

Would you like a letter sent to your family doctor? ☐Yes ☐No

Family doctor location: ☐Whitby ☐Brooklin ☐Ajax ☐Oshawa ☐Courtice ☐Port Perry

☐Bommanville ☐Other_____

Please check as many of the problems listed below that applies to you.

☐Advised by my doctor to seek treatment for my foot problem ☐I need a diabetic foot assessment

☐I can't cut my nails ☐Thick nails ☐Fungal nails ☐Ingrown nail ☐Infected ingrown nail

☐Callous ☐Corns ☐Warts ☐Dry skin ☐Sweaty skin ☐Foot odour ☐Cracked heels ☐Athlete's foot

☐Skin infection ☐Diabetic foot ulcer ☐Numb feet ☐Numb toes ☐Neuroma ☐Poor circulation

☐Heel pain ☐Plantar fasciitis ☐Arch pain ☐Bunions ☐Forefoot pain ☐Hammer toes ☐Arthritic joints

☐Ankle pain /sprain ☐Shin pain ☐Knee pain ☐Hip pain ☐Back pain

☐ I need orthotics/arch supports

☐Other

Please turn over the page and continue answering the questions concerning your foot problem.

How long have you had your nail or skin problem?

				Duration of problem			
	Both feet	Left foot	Right foot	0-3 months	3-6 months	6-12months	1-2 years
Ingrown nail	☐	☐	☐	☐	☐	☐	☐
Thick nails	☐	☐	☐	☐	☐	☐	☐
Fungal nails	☐	☐	☐	☐	☐	☐	☐
Callous/corns	☐	☐	☐	☐	☐	☐	☐
Wart	☐	☐	☐	☐	☐	☐	☐
Dry /sweaty feet	☐	☐	☐	☐	☐	☐	☐
Skin Ulcer	☐	☐	☐	☐	☐	☐	☐
Cracked heels	☐	☐	☐	☐	☐	☐	☐

On a scale of 1 to 10 please circle how painful your skin and nail problems today.

Not Painful 1 2 3 4 5 6 7 8 9 10 **Painful**

Have you been treated by any other health practitioner for this skin and/or nail problem?
☐Family Physician ☐Dermatologist ☐Chiropodist/Podiatrist ☐ Nurse ☐Pedicurist

How long have you had your bone and/or muscle problems?

				Duration of problem			
	Both feet	Left foot	Right foot	0-3 months	3-6 months	6-12months	1-2 years
Heel pain	☐	☐	☐	☐	☐	☐	☐
Arch Pain	☐	☐	☐	☐	☐	☐	☐
Forefoot pain	☐	☐	☐	☐	☐	☐	☐
Bunion pain	☐	☐	☐	☐	☐	☐	☐
Painful/numb toes	☐	☐	☐	☐	☐	☐	☐
Short leg	☐	☐	☐	☐	☐	☐	☐
Ankle pain	☐	☐	☐	☐	☐	☐	☐
Shin pain	☐	☐	☐	☐	☐	☐	☐
Knee pain	☐	☐	☐	☐	☐	☐	☐
Hip pain	☐	☐	☐	☐	☐	☐	☐
Low back pain	☐	☐	☐	☐	☐	☐	☐

On a Scale of 1 to 10 please circle how painful your bone and/or muscle problems today.

Not Painful 1 2 3 4 5 6 7 8 9 10 **Painful**

Have you been treated by any other health practitioner for this bone and/or muscle problem?
☐Family Physician ☐Chiropodist/Podiatrist ☐Chiropractor ☐ Physiotherapist ☐Pedorthist ☐Physiatrist
☐Orthopedic surgeon ☐Massage therapist

Are you taking any over the counter painkillers for your muscle and bone problems listed above?
☐Advil ☐Aspirin ☐Ibuprofen ☐ Tylenol

Has your family doctor prescribed any of the following medications for pain or inflammation?
☐Celebrex ☐Vioxx ☐ Mobicox ☐Arthrotec ☐Indomethacin

Please go to page 3 to fill out a medical questionnaire.

Medical Questionnaire

The answers to this medical questionnaire will help us to identify the cause of your foot problem.
All information will be kept confidential.

Are you allergic to any of the following drugs or substances?
☐Penicillin ☐Tape allergy ☐Aspirin (ASA) ☐Cortisone injection ☐Sulfa drug
☐Novocain (pain killing) injection at dentist ☐Food _____
☐Other drug_____ ☐Substance _____

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

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

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

Do you need to take antibiotics before going to the dentist? ☐Yes

Do you have a family history of any of the following diseases or conditions?
☐Heart ☐Stroke ☐High blood pressure ☐Diabetes ☐Vascular disease
☐Chronic obstructive lung disease ☐Asthma ☐Cancer ☐Flat feet ☐Bunions
☐ Psoriasis ☐Eczema) ☐Other_____

Are you currently taking oral contraceptives ("the pill")? ☐Yes
Are you on any of the following medications? ☐Tricyclen ☐Alesse ☐Triphasal
☐Marvelon ☐Triquilar ☐Ortho 777 ☐Cyclen ☐Minovral

Are you pregnant? ☐Yes

Do you currently smoke? ☐Yes
Have you smoked in the past? ☐Yes
How many packs per day are you smoking? ☐1/4 pack ☐1/2 pack ☐1 pack ☐2packs
Are you using any of the following medications to stop smoking? ☐Mesoderm ☐Yuban

Do you drink alcohol? ☐Yes ☐ How drinks per week? ☐1-7 ☐2-14 ☐14-36

Are you taking any of the following herbal medications: ☐Gingko biloba ☐Garlic
☐St John's wort ☐Ginseng ☐Echinacea ☐Other_____

Do you have any of the following skin or nail conditions? ☐Psoriasis ☐Eczema
☐Recurrent skin infections ☐Athletes foot ☐ Fungal nails ☐Other
Are you taking any of the following oral or topical medications: ☐Lamasil ☐Sporonox
☐Fluconazole ☐Topical corticosteroid ☐Topical antibiotic ☐Oral antibiotic

If you are not taking any medications (other than the medications already checked off) or have not been diagnosed with any type of disease, or condition by a medical doctor or have not been hospitalized for any type of injury or surgery please go to the bottom of page 6 and sign the consent to treatment. If not, continue answering the questionnaire.

Medical Questionnaire Continued

Have you been in the hospital for any of the surgeries listed below?
Check all applicable items. ☐Heart bypass ☐Organ transplants ☐Back
☐Hip or knee replacement ☐Hysterectomy ☐Cancer ☐Stomach or intestine
☐Foot surgery ☐Prostate ☐Eye ☐Artery or Vein ☐ Liver or Kidney
☐Other_____ When_____

Have you been admitted into the hospital for any of the reasons listed below?
☐Diabetes ☐Car accident ☐Injury ☐Breathing problems/Asthma ☐Infection ☐Stroke
☐Heart ☐Other_____ When_____

Do you have diabetes? ☐Yes Do you take your own blood sugar levels? ☐Yes ☐No
What readings do you get? ☐4-6 ☐6-8 ☐8-10 ☐10-12 ☐above 12
How do you control your diabetes? ☐Diet ☐Exercise ☐Glyburide ☐Metformin ☐Avandia
☐Actos ☐Insulin

Do you have past history or currently have high blood pressure? ☐Yes
Are you taking any of the following medications: ☐Hydrochlorthiazide ☐Furosemide
☐Altace ☐Norvasc ☐Vasotec ☐Monopril ☐Atenol ☐Accupril ☐Spirolactone
☐Renedil ☐Zestril ☐Adalat ☐Atenol ☐Inhibace ☐Cozaar ☐Diovan
☐Lisnopril ☐Coversyl ☐Slow K

Do you have past history or currently have high cholesterol? ☐Yes
Are you taking any of the following medications: ☐Lipitor ☐Zocor ☐Provastatin
☐Lipidil ☐Pravachol

Have you previously had a diabetic foot ulcer or foot infection? ☐Yes

Do you have weakness/numbness/tingling in your legs/arms/hands or feet? ☐Yes

Do you get cramps in your legs either while walking or sleeping at night? ☐Yes

Do you currently have to take medication to prevent you blood from clotting? ☐Yes
Are you taking any of the following medications: ☐Aspirin (ASA) ☐Coumadin
☐Warfarin ☐Plavix ☐Novasen

Have you ever had either stroke ☐Yes, or a blood clot in your leg? ☐Yes

Do you have past history or currently have the following heart problems:
☐Heart attack ☐Angina ☐Congestive heart failure ☐Irregular heart beat ☐Murmur
Are you taking any of the following medications for you heart problem:
☐Digoxin ☐Lanoxin ☐Metoprolol ☐Lopressor ☐Propranolol ☐Nitrodur ☐Atenol
☐Diltiazem ☐Nitrolingual ☐Imdur

Medical Questionnaire Continued

Do you have either osteoarthritis ☐Yes, **or rheumatoid arthritis** ☐Yes, **or fibromyalgia?** ☐Yes. Are you taking any of the following medications:
☐Celebrex ☐Vioxx ☐Mobicox ☐Ibuprofen ☐Naproxen ☐Arthrotec ☐Aspirin
☐Tylenol ☐Prednisone ☐Aspirin ☐Methotraxate ☐Gold salts ☐Penicillamine

Do you have osteoporosis? ☐Yes
Are you taking any of the following medications: ☐Fosamax ☐Didrocal ☐Cal 500
☐ApoCal ☐Actonel ☐Evista

Do you have gout? ☐Yes. Are you taking any of the following medications:
☐Allopurinol ☐Indomethacin

Are you experiencing any anxiety, difficulty sleeping, or depression, etc? ☐Yes
Are you taking any of the following medications: ☐Paxil ☐Effexor ☐Celexa ☐Wellbutrin
☐Sertraline ☐Zoloft ☐Lorazepam ☐Diazepam ☐Amitriptyline ☐Imovane
☐Temazepam ☐Risperdal ☐Zyprexa ☐Seroquel ☐Oxazepam

Do you suffer from persistent back problems? ☐Yes
Is a physiotherapist or chiropractor treating you? ☐Yes
Are you taking any pain medications? ☐Yes

Have you suffered from sciatica? ☐Yes

Have you ever had the following blood borne infections? ☐Hepatitis A, B, or C ☐HIV

Do you have past history or currently have the following eye problems:
☐Glaucoma ☐Cataracts ☐Macular degeneration
Are you taking any of the following medications: ☐**Xalatan** ☐**Alphagan**

Have you ever had rheumatic fever as a child or an adult? ☐Yes

Do you have past history or currently have the following problems with your blood:
☐ Anemia ☐Excessive bleeding ☐Sickle cell ☐Other _____
Are you taking any of the following medications: ☐Folic acid ☐Vitamin B12 ☐Iron

Do you have the following breathing problems: ☐Asthma ☐Bronchitis
Are you taking any of the following medications: ☐Salbutamol ☐ Combivent ☐Atrovent
☐Pumicort ☐Singulair ☐Zervent ☐Flovent ☐Nasonex ☐Advair

Do you have tuberculosis? ☐Yes

Do you have any of the following stomach or digestive problems:
☐Hiatus hernia ☐Ulcer ☐Gastritis ☐ Irritable bowel syndrome ☐Constipation
Are you taking any of the following medications:
☐Losec ☐Pantolor ☐Ranitidine ☐Nextum ☐Senokot ☐Soflax (docusate sodium)

Medical Questionnaire Continued

Do you have past history or currently have liver or gall bladder problems? ☐Yes

Do you have kidney problems or recurrent bladder infections? ☐Yes

Do you have prostate problems? ☐Yes.
Are you on any of the following medications: ☐Flomax

Do you currently have any of the following nervous system problems listed below:
☐Epilepsy ☐Parkinson's disease ☐Cerebral palsy ☐Muscular dystrophy
Are you taking any of the following medications: ☐Levodopa ☐MAO Inhibitors
☐Dilantin ☐Clonazepam ☐Divalproex ☐ Gabapentin

Do you currently suffer from migraines? ☐Yes
Are you taking any of the following medications: ☐Imitrex ☐Propanolol

Do you have an overactive or an under active thyroid gland? ☐Yes
Are you taking any of the following medications: ☐Synthroid ☐Eltroxin

Are you currently on estrogen or progesterone replacements? ☐Yes
Are you taking any of the following medications: ☐CES ☐Premarin ☐Estrace
☐Estraderm ☐Prometrium ☐Provera ☐Estrogel

Do you have any other medical conditions or are you using any other medication that was not asked about in this questionnaire.

◊◊

Consent to Treatment

I hereby give my permission to the chiropodists at Whitby Family Footcare Clinic to examine and treat my feet by medical, orthopedic, or minor surgical methods.
All information will be kept confidential and will not be released to any person or 3rd party without your written consent.
I acknowledge that chiropody fees are NOT covered by OHIP.

DATE ________________ **SIGNATURE**____________________________________
M D Y

Thank you for your cooperation, we will be with you in a moment.