Gentle Foot Care 268 Lakeshore Rd. E. Suite 100, Mississauga, Ontario,L5G 1H1
Phone: 905 891-9009 Fax: 905 891-9004 Email: footproblems@hotmail.com

CASE HISTORY FORM

Name:_____ Date: D M Y _____

Address:_____
City/Town Postal Code

Telephone: Home_____ Alt. Phone:_____

Date of Birth D M Y _____ Age:_____ Weight:_____ Height:_____

Medical Doctor:_____ Phone No:_____ Fax: _____

Occupation:_____ Where did you first hear about our office:_____

Shoe Size: _____ Email _____

Preferred contact method: Home Phone Cell Phone
Business Phone Email

Consent for sending our seasonal newsletter and appointment reminder via email: YES NO

Reason for Visit: _____

Previous care by a ☐Chiropodist? ☐Podiatrist? If yes date of last visit:_____

Referred to this centre through:

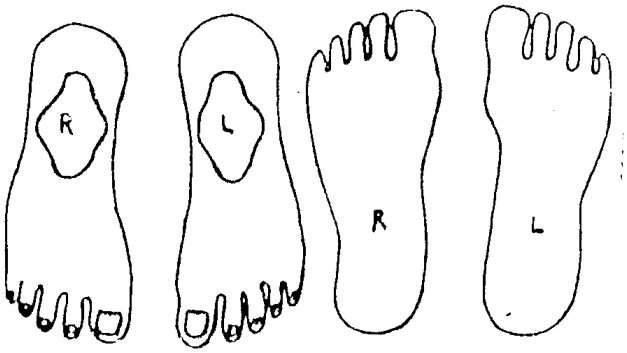
On the diagrams provided below, mark the areas on your lower limbs and feet which you feel best represents the pain or sensation you are experiencing.

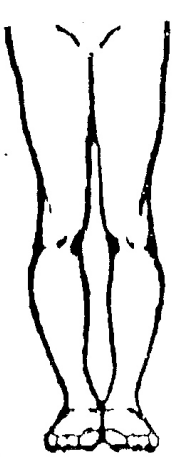
SYMBOLS

XX Burning **SS** Sharp and Stabbing ++ Dull / Aching

NN Numbness **PP** Pins and Needles

TOP BOTTOM





FRONT BACK

Health History

Please check those items that specifically relate to your medical history. Please answer these questions carefully, as they will be considered in establishing a suitable treatment plan for you.

Head/Ears/Eyes/Nose/Throat

☐Frequent Headaches ☐Ringing in Ears ☐Glasses/Contacts ☐Nose Infections

☐Previous Head Injury ☐Difficulty Hearing ☐Vision Problems ☐Throat Infections

☐Fainting Spells ☐Dizziness ☐Convulsions/Seizures

Other ? Please Specify: _____

Cardiovascular System

☐High Blood Pressure ☐Heart Disease ☐Chest Pain ☐Poor Circulation

☐Low Blood Pressure ☐Heart Attack ☐Bleeding Disorders ☐Numbness

☐Angina ☐Stroke ☐Leg Cramps ☐Swollen Ankles

☐Varicose Veins Other? Please Specify: _____

Respiratory

☐Shortness of Breath ☐Smoker # of cigarettes smoked per day

☐Asthma ☐Non Smoker ☐Have you ever smoked in the past? How Long?

Other? Please Specify: _____

Endocrine

☐Diabetes ☐Thyroid ☐Addisons Disease

☐Cushings Syndrome Other? Please Specify: _____

Musculoskeletal

☐Joint Pain ☐Joint Stiffness ☐Joint Swelling ☐Limited Joint Movement

Area:_____ Area:_____ Area:_____ Area:_____

☐Osteoarthritis ☐Rheumatoid Arthritis ☐Osteoporosis ☐Muscle Weakness

Have you ever fractured/
Broken any bones? Where? _____

Other? Please Specify: _____

Gastrointestinal/Genitourinary

☐Poor Appetite ☐Excessive Thirst ☐Frequent Urination ☐Kidney/Liver Disease

☐Rapid Weight Loss ☐Excessive Hunger ☐Trouble Urinating ☐Stomach Ulcers

Other? Please Specify: _____

Childhood Illnesses

☐Rheumatic Fever Other? Please Specify: _____

Skin and Nails

☐Dry/Cracking Skin ☐Sensitive Skin ☐Dry/ Brittle Skin ☐Discoloured Nails

☐Moist (Sweaty) Skin ☐Rashes/Itching ☐Fungal Infections ☐Foot/Leg Ulcers

☐Slow to Heal ☐Warts ☐Bruise Easily ☐Callous/Corns

Other? Please Specify: _____

Surgery

☐Foot Surgery ☐Joint Replacement ☐Organ Transplant

Other? Please Specify: _____

Allergies

Have you ever had any allergies?

Other? Please Specify: _____

Psychological

☐Depression ☐Anxiety/Nervousness

Other? Please Specify: _____

Other

Have you ever been hospitalized? Reason:

If there are any other relevant medical conditions not covered on this form please outline then here:

Medications:

Please list any medications that you are currently taking below:

_____

_____

_____

_____

Have you ever experienced any side effects from local anesthetics, penicillin or other medications? If so please specify:

_____

_____

Please inform the Chiropodist if you ever tested HIV positive or have been diagnosed with hepatitis.

I acknowledge that all of the above information is correct. I understand that this information is confidential and will be used for no other purpose other than for the Chiropodists clinical record.

Informed Consent To Chiropodist Care

I hereby give permission for the examination and assessment of my feet, as well as give consent to perform such diagnostic procedures as may be deemed necessary.

I understand and I am informed that, as in all health care, in the practice of Chiropody there maybe some very slight risks to treatment. I wish to rely on the Chiropodist to exercise judgment during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to treatment by the Chiropodist. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____ _____

Signature of Patient/Parent **Date Signed**

_____ _____

Signature of Witness **Date Signed**