Maczko Chiropody
Foot Care Clinic

559 Exmouth Street, Sarnia Ont. N7T 5P6
Tel: (519) 337-9540 Fax: (519) 337-2566

The answers to the following questions serve as a guide in planning thorough foot care for you. Please complete the following. **PRINT CLEARLY**

1. **NAME: _____DATE OF BIRTH** _____
LAST **FIRST** DAY MONTH YEAR

2. **ADDRESS: _____ POSTAL CODE: _____**
NO. & STREET APT. NO CITY

3. **Email Address**: _____

4. **TELEPHONE (HOME) _____(WORK)_____(CELL)_____**

5. Height _____ Weight _____ Shoe Size _____

6. **OCCUPATION: _____ FAMILY PHYSICIAN _____**

7. Do you have extended health insurance? ☐ No ☐ Yes Company _____

8. How did you learn about Maczko Chiropody Foot Clinic?

____Physician ____Friend ____Relative ____Nurse ____Other Health Care Provider
____Newspaper____Telephone Book____Website ____Radio ____Other

9. Do you have Diabetes? ☐ YES ☐ NO Insulin Dependent ☐ YES ☐ NO

10. Briefly describe your most concerning foot/leg concerns: (in order of importance)

A) _____ B) _____

C) _____ D) _____

11. Have your feet changed in the last year? ☐ YES ☐ NO If yes, how?

_____

_____

_____

12. Do you have any of the following conditions? Please mark a check ✓ beside those that apply.

__ High Blood Pressure __ Arthritis __ Kidney Problems __ Psoriasis __ Multiple Sclerosis __ Heart Problems __ Gout __ Liver Conditions __Osteoporosis __ Asthma __ Stroke	__ Diabetes __ Parkinson's __ Depression __ Circulation Problems __ Nails __ Calluses __ Corns __ Swelling __ Toe Problems __ Cold Feet __ Cramping	__ Infections __ Itchiness __ Open Sores __ Ankle Pain __ Knee Pain __ Hip Pain __ Back Pain __ Frequent Headache __ Tired Feet __ Bunions __ Fibromyalgia	Other not listed: _____ _____ _____ _____

13. Please provide a list of any pharmacy medications or herbal products that you currently use:

_____
_____
_____

14. Do you have allergies to any medications or topical treatments (creams, or any products, etc.)?

_____
_____

15. Have you had any previous injuries to your feet or ankles? If yes, please describe: ----

_____
_____
_____
_____

16. I hereby give my permission to the Chiropodist at the Maczko Chiropody and Orthotic Centre to examine and develop a treatment plan for the care of my feet and related issues and symptoms. I also acknowledge that Chiropodist fees are **NOT** covered by OHIP. First visits are $70 as this is an assessment and treatment and follow appointments are $45. A letter may be sent to my Physician regarding any visit(s) to Maczko Chiropody and Orthotic Centre. If orthotics are required, an additional cost of $450.00 IS DUE IN FULL THE DAY of assessment. **All missed appointments will be charged a fee of $45 payable before you schedule your next appointment.** All information will be kept confidential and will not be released to any other person or third party without my written consent.

_____ _____

DATE PATIENT SIGNATURE