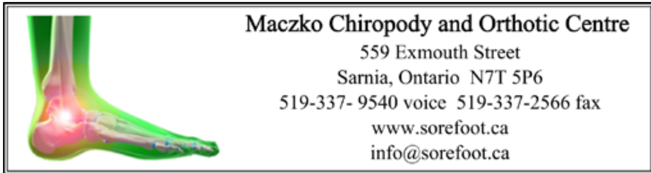

Please complete the following. **PLEASE PRINT CLEARLY**

1. **NAME:** ____ **DATE OF BIRTH** ____________________
LAST **FIRST** DAY MONTH YEAR

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

3. **Email Address**: ____
***would you like a reminder of your appointment? ☐ by email ☐ by phone ☐ No reminder call**

4. **TELEPHONE (HOME)** __________________**(WORK)**________________**(CELL)**________________

5. Height ______________________ Weight _________________ Shoe Size _______________________

6. **OCCUPATION:** ___________________________ **FAMILY PHYSICIAN** ______________________

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

____

____

____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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:
***if you have a written list, we can photocopy and return it to you**

____

____

____

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 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 $75 as this is an assessment and a treatment and follow up appointments are $50. A letter may be sent to my Physician regarding any visit(s) to Maczko Chiropody and Orthotic Centre. **All missed appointments will be subject to a fee of $50.00 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