A STEP AHEAD FOOT CLINIC MEDICAL HISTORY AND CONSENT FORM

Patient Name: _____ Male ☐ Female ☐ Date: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth (D/M/Y): _____ Family Doctor: _____

Home Phone: _____ Emergency Contact: _____

Cell Phone: _____ Relation: _____

Work Phone: _____ Phone: _____

How did you hear about us? _____ Shoe Size: _____ Weight: _____

If applicable: Private Insurance Company _____ Smoker ☐ Ex-Smoker ☐

CONSENT

Please indicate consent with your signature below.

- I provide consent for assessment and treatment (including various modes of physical therapy) by the Chiropodist and/or support staff, and also to photographs to be taken for the purposes of monitoring.
- I understand that I am financially responsible for all fees and that these are payable at the time the service is provided. Receipts will be issued to claim reimbursement from health plans or for income tax purposes. An appointment fee will be applied for appointments cancelled with less than 24 hours notice and for missed appointments.
- I authorize A Step Ahead Foot Clinic to request/release medical information regarding my diagnoses, treatment and prognosis from/to persons relevant to my care (physicians/health care providers/ funding sources/etc).
- I understand that personal information collected/released by A Step Ahead Foot Clinic (paper, electronic, photographic) will be treated with respect and comply with Privacy Legislation, the Standards of the College of Chiropodists of Ontario, and the Law. I understand, I may view A Step Ahead Foot Clinic's Privacy Policy on request.
- I consent to email/text communications for appointments, financial documents, and occasional marketing.
- **My preferred method for appointment confirmations is: email ☐ or text ☐**

EMAIL ADDRESS: _____ **SIGNATURE**: _____

For what reason(s) are you visiting us today?	
Relevant Surgeries and Injuries (Eg. Back or lower limb surgeries, ankle sprains, fractures, sports/work injuries, car accidents)	
Allergies Eg.Drug, shellfish, latex, adhesives	
Prescription and Off-the-Shelf Medications, and Herbal/Natural Remedies (Include Reason)	Check if nothing was recorded because a separate list was provided ☐

Please complete the back side of this form as well

Please "check" if any of the following apply to you and provide further details if needed.

Diabetes	□ **Type 1 (Childhood Onset) or □ Type 2 (Adult Onset)** Controlled Using: □ Insulin □ Pills □ Diet (check all that apply) **Year of Onset** _____ Usual Blood Sugar Reading_____Last A1C Reading: _____ Additional Information:
Cancer	Type: _____ Year of Onset _____ Treatment: □ Chemotherapy □ Radiation □ Surgery Additional Information:
Head, Eyes, Ears, Nose & Throat	□ Vision Issues (glaucoma, cataracts, macular degeneration) □ Managed with glasses/contacts
	□ Hearing Issues □ Managed with hearing aids
Respiratory	□ Asthma
	□ Emphysema/COPD
Cardiovascular	□ Angina
	□ Arrhythmia
	□ Stroke
	□ High Cholesterol □ Managed with medication
	□ High Blood Pressure □ Managed with medication
	□ Heart Attack
	□ Swollen Feet or Ankles
	Please circle if you have had a: bypass, angioplasty, stent, valve replacement, pacemaker
Digestive, Urinary, & Reproductive	□ Acid Reflux/Indigestion
	□ Stomach or Digestive Ulcer
	□ Hernia
	□ Pregnant or Nursing
Endocrine	□ Hyperthyroid (high thyroid, can have weight loss)
	□ Hypothyroid (low thyroid, can have weight gain)
	□ Kidney Disease
	□ Liver Disease
Orthopaedic	□ Osteo-Arthritis
	□ Rheumatoid Arthritis
	□ Joint Stiffness or Pain
	□ Gout
	□ Fibromyalgia
Neurologic	□ Alzheimer's Disease or other Dementia
	□ Multiple Sclerosis
	□ Parkinson's Disease
	□ Tingling, Pins/Needles, or Loss of Feeling
	□ Lupus
	□ Epilepsy
Psychiatric	□ Anxiety
	□ Depression
	□ Sleep Disorder
Blood Disease	□ HIV / AIDS
	□ Anemia
	□ Hepatitis
	□ Hemophilia or Other Blood-Clotting Problems
Assistive Devices	□ Cane □ Walker □ Wheelchair Other:

Additional Comments regarding any of the above:

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