Clarke Ventresca
FOOT & ORTHOTIC CENTRES

www.cvfoc.com

PATIENT INFORMATION: (PLEASE PRINT)

First Name _____ Last Name _____

Address _____ City _____ Postal Code _____

Phone (H) _____ Cell _____ Business _____

Date of Birth (D/M/Y) _____ Email address _____

Occupation _____ Employer _____ May We Contact You at Work: Y N

Emergency Contact _____ Relationship _____

Phone _____

Parent/Guardian Names (if child is under 18) _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

Friend/Family/Colleague _____

Internet □ Newspaper □ Health Care Professional □ Yellow Pages □ Outside Sign □

Help us help you!

Your foot problems involve:

Right foot only □ Left foot only □ Both feet □

Why are you here today?

_____

_____

Have you sought treatment elsewhere? Y N

Have you ever been treated for or currently suffer with? (check all that apply)

□ Back pain
□ Warts
□ Heel pain
□ High arch feet/pain
□ Corns
□ Callouses
□ Bunions
□ Hammertoes
□ Gout
□ Broken foot/leg bones
□ Flat feet
□ Ankle injury
□ Neuroma
□ Knee pain
□ Ingrown nails
□ Childhood foot problems

What is your current:

Height: _____ Weight: _____ Shoe Size: _____

In an average day, how much are you on your feet?

□ 20% □ 40% □ 60 % □ 80% □ 100%

What type of footwear do you wear most for work or leisure?

□ Safety shoe/boot □ Athletic □ Dress □ Sandal
□ Other _____

Do you currently use orthotics? (shoe inserts) Y N

Check any sports or activities you participate in <u>regularly</u>:

□ Walking
□ Aerobics/Aqua Fit
□ Hockey
□ Racquet Sports
□ Running
□ Golf
□ Soccer
□ Skiing
□ Other: _____

Please answer the following questions:
Do you have or have you ever been treated for?
(Check all that apply)

□ Diabetes: Type 1 Type 2 How long? _____
□ Heart Trouble □ Skin Disorder
□ Hepatitis □ Thyroid Problem
□ Liver Disease □ HIV/AIDS
□ Urinary Problem □ Blood Disease
□ Depression □ Anxiety
□ High Blood Pressure □ Bone Disease
□ Cholesterol □ Arthritis
□ Cancer □ Epilepsy
□ Shortness of Breath □ Tuberculosis
□ Stroke □ Stomach/Bowel Trouble
□ Multiple Sclerosis □ Varicose Veins
□ Heart Attack □ Circulation Problems
□ Other _____

Do you have any known allergies to?

Local anesthetics (e.g. Xylocaine, Novocaine) □ Y □ N
Adhesive tape/band-aids □ Y □ N
Latex □ Y □ N
Other: _____
_____
_____
_____
Are you slow to heal after cuts? □ Y □ N
Do you bruise easily? □ Y □ N
Are you currently pregnant or nursing? □ Y □ N

Patient Physicians & Medical Specialists:

Family Physician: _____
_____
Phone: _____

PLEASE LIST YOUR CURRENT MEDICATIONS (we can photocopy your list):

_____
_____
_____
_____
_____

Please read & sign below:

I understand that **I am financially responsible for all charges**, whether covered by my health insurance plan or not. I authorize the Chiropodist to release all information necessary to secure the benefit of payments. I understand that fees for service are payable at the time of service and insurance reimbursement is my responsibility.

I hereby give consent for examination and treatment by the Chiropodist and/or anyone working in the clinic authorized by the Chiropodist and allow photographs of treatment areas for the purpose of monitoring.

I consent/allow the Chiropodist to send my Physician or health care professional a report regarding my foot exam and treatment plan.

□ I agree to receive Clarke Ventresca Foot and Orthotics Centre's newsletter containing news, updates and promotions. You can withdraw your consent at anytime.

Signature _____ Date _____