



London Foot Specialists
279 Wharnccliffe Road North
Suite 108, London ON, N6H 2C2
Tel: (519) 432 3636

Stratford Foot & Ankle Clinic
502 Huron Street
Stratford, ON, N5A 5T7
Tel: 519-271-8834

Ingersoll Foot & Ankle Clinic
238 Thames Street South,
Ingersoll, ON, N5C 2T5
Tel: (519) 485-1750

PATIENT INFORMATION

Welcome to our Practice

Mr. Mrs. Ms. Miss. Dr. Other _____

Male

Female

Patient First Name _____ Middle Name _____ Last Name _____

Patient Home Street Address _____ Apt# _____

City _____ Province _____ Postal Code _____

Patient Home Phone# [] _____ Cell Phone# [] _____ Work# [] _____

Patient Date of Birth ____/____/____ Patient Email Address [please print clearly] _____
Day Month Year

Name of Family Physician _____ Date of Last Visit _____

Patient Occupation _____ Employer Name _____

Emergency Contact Name _____ Phone _____ Relationship _____

Patient Height _____ Weight _____ Shoe Size _____

Do you currently use orthotics? (shoe inserts) _____

If you have had foot x-rays or diagnostic tests, when were they taken? _____

PREFERRED CONTACT METHOD

Home Phone Cell Phone Work Email

If the patient is a minor (Under 18) - provide name of parents or guardian _____

Address of parents or guardian _____

Phone# [] _____ Cell Phone# [] _____

REFERRAL INFORMATION

We appreciate your referrals! Whom may we thank for referring you to our office?

Name _____ Address _____

Is this person your: Family Doctor Other Specialist Family Member Friend

Other Referral Sources [check all that apply and please specify names where indicated]:

Internet Search (name)	Phone Book (name)	Our Practice Website	Newspaper Ad (name)	Saw Our Sign	Insurance Plan Or Website (name)	Other (name)

Please turn over and complete

PODIATRIC HISTORY

Have you ever been to a podiatrist / chiropodist before? Yes No

WHAT IS YOUR MAIN FOOT COMPLAINT TODAY?

Your foot problem involves: Right Foot Only Left Foot Only Both Feet

When did it begin? _____

Did you receive treatment for this condition? Yes No

If so, what type? _____

Circle the **degree of pain** you are currently experiencing:

Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **foot conditions**?
Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Ankle Instability | <input type="checkbox"/> Ingrown Toenails |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Intoe - Out toe walking |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Blisters | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Limb Length Discrepancy |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Neuromas |
| <input type="checkbox"/> Burning Feet | <input type="checkbox"/> Numbness or tingling in foot or toes |
| <input type="checkbox"/> Corns/Calluses foot or toes | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Diabetic Evaluation | <input type="checkbox"/> Postural Fatigue |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pronation |
| <input type="checkbox"/> Fracture (foot/ankle/leg) | <input type="checkbox"/> Shin Splints |
| <input type="checkbox"/> Fungal Infections (skin/nail) | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Sweating/Odor |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Tired feet |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Warts |

MEDICAL HISTORY

Have ever been treated for any the following conditions?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Acid Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypothyroidism |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Irritable Bowel Syndrome |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle or Joint Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral Arterial Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Phlebitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No Poor Circulation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure Disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/Aids | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hyperthyroidism | <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins |

MEDICATIONS

Are you curenly on Blood Thinners? Yes No

Can you provide a printed list of your medications or list them below:

Name of Medication	Strength / Mg	Taken how often?

Do you currently use: Cigarettes or Tobacco? Yes No Quit

If yes, for how long? _____ How many pks/day? _____

Are you currently pregnant or nursing? Yes No

Alcohol use? Yes No If yes, quantity ____ daily ____ weekly

SURGERIES

Please List All Surgeries	Approximate Date

If other, please explain _____

ALLERGIES

Have you every had adverse side effects or allergies to:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Adhesive Tape | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal/Jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anticoagulants | <input type="checkbox"/> Yes <input type="checkbox"/> No Novacaine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anti-Inflammatory Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No Peanuts |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No Seafood |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone | <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No Other Pain Medication |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Other |

If other, please explain _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

I hereby allow and consent to examination and treatment by the Chiroprapist and/or staff, and allow photographs of treatment areas to be taken for the purposes of monitoring.

I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service fees are payable at the time service is provided.

I hereby state that the above information is true and accurate and give my permission to J. Craig Hunt B.Sc., D.Ch., PgD., to administer treatment and to perform such operative procedures as may be deemed necessary in the diagnosis and/or treatment of mv foot condition.

Patient Signature (or guardian) _____

Date _____