KINGSWAY FOOT CLINIC

FOOT CARE - CUSTOM ORTHOTICS

3101 BLOOR ST WEST SUITE 203
TORONTO, ONTARIO M8X2W2

TELEPHONE:
(416) 239-3338
(FEET)

We are pleased you have confided in us for your foot care. The staff wished to welcome you to our office. We take pride in our professional capabilities and will attempt to accommodate you in every way possible. We accept new patients without Doctor referral. Adult foot problems begin in childhood. Please have your children's and / or grandchildren's feet examined twice yearly.

Please answer the following questions fully to help us become better acquainted. If you need assistance do not hesitate to ask the receptionist.

Name _____ Today's Date _____
First Last

Parent or guardian, if a minor _____

Home Address _____ City _____ Postal Code _____

Phone number (Home) (____) _____ (Work) (____) _____

Fax (____) _____ Cellular Phone (____) _____

Date of birth MONTH ____ DAY ____ YEAR ____ Sex F ☐ M ☐ E-mail: _____

Shoe Size _____ Weight _____ Height _____ Age _____

Occupation _____

Employer _____

Business Address _____

	Yes	No
Does your occupation keep you on your feet?	☐	☐
Do you have chiropody insurance. If yes, name of insurance co. _____	☐	☐
Are you or your spouse under any additional type of medical insurance that covers prescriptions, eyeglasses or dental. e.g. Great West Life, Sunlife, Manulife etc. _____		
How did you hear about our office, or who referred you? _____		
Have you had a medical examination in the last year?	☐	☐
Have you ever had foot, back, hip or knee surgery?	☐	☐
Are you allergic to medications, materials or local anaesthetic (freezing)	☐	☐

If yes, specify _____

Are you diabetic? ☐ Yes ☐ No ☐ Unsure

Is there a personal or family history of diabetes? ☐ Self ☐ Mother ☐ Father

Yes No

Do you take any medications regularly? (Including aspirin) ☐ ☐

(Please list) _____

Are you subject to prolonged bleeding? ☐ ☐

Are you prone to infection? ☐ ☐

Have you been treated or had surgery for any serious medical problems, ie. Heart, Kidney, etc.?

(Please list) _____

Have you ever fainted in a doctor's office? ☐ ☐

Name of family doctor _____ Last visit _____

Address or street _____ Phone (____) _____

Have you ever had your feet examined? By whom? _____ ☐ ☐

What is your foot problem? _____

_____

MEDICAL CONDITIONS	Please check off any of the following conditions you presently have or have had. (If not sure, please check NS)									
	Yes	No	NS		Yes	No	NS		Yes	No	NS
Tuberculosis				Anorexia/Bulimia				High/Low Blood Pressure			
Lung Disease				Psychiatric Care				Shortness of Breath			
Asthma				Thyroid Disease				Hepatitis/Liver Disease			
Epilepsy				Swelling of Ankles				Painful or Swollen Joints			
Aids/HIV				Kidney Disease				Cancer or Tumor			
Venereal Disease				Blood Disorders				Radiation/Chemotherapy			
Skin Disease				Anemia				Ulcers or Stomach Trouble			
Poor Circulation				Rheumatic Fever				Arthritis			

Is there anything we have not mentioned that you think we should know regarding your medical history?:

Females ONLY

Females - Are you pregnant? ☐ Yes ☐ No ☐ Unsure

If yes or unsure, please inform the receptionist!

Are you nursing? ☐ Yes ☐ No

Females - Do you wear high heels? ☐ Occasionally ☐ For work ☐ Daily ☐ Never

Hartley J. Silver D.Ch. is a Chiropodist, consequently there is a fee for examination and/or treatment. You are responsible for fees the day of your visit.

I hereby give permission to Hartley J. Silver, D. Ch. to assess and recommend / administer treatment for my foot condition as deemed necessary.

_____ _____

Date Signature

Occasionally, we must change or confirm a future appointment. Who can we call if we cannot reach you? (neighbour, relative friend etc.) Phone number ( )

Name _____ Relationship _____