New Tecumseth
Family Footcare
A Step Toward Better Health

Division of 1194466 Ontario Ltd.

New Patient Registration Form

Please Note:
Any information provided by the patient will assist us in treating you safely and effectively. Feel free to ask any questions about the information being requested. Note that any information provided will be kept confidential unless your written permission allowed otherwise or required by law. The Rules of Civil Procedure in Ontario require that we produce, upon request, photocopies of the attending doctor's clinical notes and records, consultation notes, radiology reports, x-ray reports, and lab results that we may have in our possession. Your written permission will be required to release any information otherwise.

Please complete the following information:

Patient's Name: _____ Phone: (H) _____ (W) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Sex: M F Height:_____ Weight:_____ Shoe Size:_____

Date of Birth: mm____dd____yy_____.

Occupation: _____ E-mail address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Benefits Insurance Provider: _____

Family Physician: _____ Phone: _____ Fax: _____

How were you referred to our office? _____

A personal referral is the highest compliment that a patient can give to their practitioner. If you have been referred by another patient you have the option of providing their name, so we can thank them with a referral appreciation certificate: _____

50 Main Street East, Unit 6B, Beeton, Ontario L0G 1A0
Tel: 905-729-0782 Fax: 905-729-4009

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Foot Health Information:

Please circle your selections below:

- Please describe your foot problem and what brings you to our office today? _____
  _____
- If you are having pain, how would you describe your pain?
  Sharp aching throbbing burning shooting electrical sensation Pins and needles
- How long has your problem been present?
  <3 days <7 days <3 weeks <6 weeks <6 months <9 months <1 year >1 year
- Sustained injury or accident, date of occurrence: mm____dd____yy____.
- Have you attempted any treatment to relieve your problem? Rest, elevation, OTC pads, ice, change in shoe styles, OTC medication (Tylenol, Advil, Motrin, etc), stretching, Other: _____
- Diabetes _____ yes/ no
- Respiratory (asthma, pneumonia, emphysema) _____ yes/ no
- Cardiovascular (heart attack, stroke, high blood pressure, poor circulation) yes/ no
- Thyroid _____ yes/ no
- Arthritis _____ yes/ no
- Skin Conditions (eczema, psoriasis) _____ yes/ no
- Neurological (stroke, numbness or tingling, loss of sensation) _____ yes/ no
- Cancer (present or history of) _____ yes/ no
- Gout _____ yes/ no
- Communicable Disease (Hepatitis, HIV) _____ yes/ no
- Previous Surgeries _____ yes/ no
- Hearing Loss _____ yes/ no
- Eye Conditions _____ yes/ no
- Other Conditions we should know about _____
- Injuries/Accidents _____ yes/ no
- Allergies (environmental, Medications) _____ yes/ no
- Smoker _____ yes/ no
- How much time do you spend on your feet each day: < 2hrs. < 4hrs. <7hrs. >7hrs.
- Have you worn or do you currently wear orthotics _____ yes/ no
- Knee, Hip, or Lower Back pain _____ yes/ no
- Sports/ Physical activities _____ yes/ no
- Sports/ Physical activities in the past _____ yes/ no
- List current Medications: _____

Patient Signature: _____ Date: _____

Chiropodist Signature: _____ Date: _____