

ANCASTER FOOT CLINIC

2-352 Wilson St. E., Ancaster, ON L9G 2C2 — 905-648-9176

Robert Nekrasas, D. Ch. — Chiropodist — Reg# 960423

CONSENT TO EXAMINATION, TREATMENT AND DIAGNOSTIC PROCEDURES

Name: _____

Date of Birth: _____

Date: _____

1. I authorize chiropodist Robert Nekrasas, D. Ch., to perform examinations, treatments and diagnostics procedures within the scope of practice as outlined by the College of Chiropodist of Ontario. I also understand that authorized personnel may assist him in performing these procedures.
2. I also consent to such additional or alternative diagnostic, operative or treatment procedures as in the opinion of the medical staff performing the procedures mentioned are considered incidental to, or immediately necessary and vital to health and life of the patient.
3. I agree to the retention by Robert Nekrasas, D. Ch. for the diagnosis, research, teaching or therapy or the disposal in accordance with the accustomed practice any material that may be removed during procedures.
4. I acknowledge that there may be a charge applied by the chiropodist for the consultation, visit and treatment. I agree to pay all charges in full when they are applied _____ (initials)
5. I give permission for relevant medical information to be shared between my family physician and Ancaster Foot Clinic.
6. I certify that all the information I provide is complete and accurate _____ (initials)
8. We do not disclose any information contained in patient files without the strict written consent of the patient.

Signature of Patient: _____

P A T I E N T

Last Name: _____ First Name: _____

Date of birth: _____ Gender: _____

Address: _____

City: _____ Postal Code: _____

E-mail: _____ Occupation: _____

Phone: (H) _____ (C) _____ (B) _____ ext _____

Weight: _____ Height: _____ Referred By: _____

Family Physician: _____ Dr's tel.: _____

Medical Information

Do you have Diabetes? Y _____ N _____ **Do you have Neuropathy?** Y _____ N _____

Are you **in good health?** Y _____ N _____

Have you been under a **physician's care** in the last two years? Y _____ N _____

Have you ever had **severe chest pains** or shortness of breath? Y _____ N _____

Are you subject to **prolonged bleeding?** Y _____ N _____

Have you ever fainted or **passed out** in a doctor's office? Y _____ N _____

Do you have low **back pain?** Y _____ N _____

Are you currently **pregnant?** Y _____ N _____

Do you now or have you ever **smoked?** Y _____ N _____

Which hand do you most often use? R _____ L _____ B _____

Have you had any **major operations?** _____

Have you ever been treated for any of the following?

Heart	Kidney	Asthma	Phlebitis	Epilepsy	Anemia
Liver	Cancer	Ulcers	Gout	Arthritis	Clotting
Parkinson's	Scarlet Fever	Rheum Fever	High BP	Low BP	Healing Problems
AIDS	Thyroid	Psoriasis	Blood borne infections	TB	

P A T I E N T

Podiatric Information

Do you ever have foot or leg **cramps**?Y_____ N_____

Do you ever get **numbness** in your feet or toes?Y_____ N_____

Do you ever get **tingling** in your feet or toes?Y_____ N_____

Have you ever had any **itching** in your feet?Y_____ N_____

Have you ever had any major foot or **leg injuries**?Y_____ N_____

Have you ever had any foot or **leg surgery**?Y_____ N_____

Do or did **your parents** ever have any foot problems?Y_____ N_____

Do your feet **perspire** excessively?Y_____ N_____

Are your feet excessively **dry**?Y_____ N_____

Do your feet have a strong **odour**?Y_____ N_____

Do you treat your own feet or cut your own **callouses**?Y_____ N_____

Have you ever had your feet treated **before**?Y_____ N_____

By a Podiatrist_____ Chiropodist_____ Orthopedic Surgeon_____ Pedicurist_____ Other_____

Do you generally find your feet to be.....Hot_____ Cold_____ Normal_____

When walking, do you.....Toe In_____ Toe Out_____ Walk Straight_____

History

What is **your specific foot problem**? _____

How long have you had this problem? _____

What have you **done** about it? _____

Has this condition been seen by your **family doctor**? _____

Or **other clinician**? _____

Result of this care? _____

Does this problem affect your walking or **normal functioning**? _____

How much? _____

P A T I E N T

What type of pain is it?

Sharp Bruised Aching
Dull Throbbing Hot
Sore Stabbing Tender
Numb Burning Other

Onset

Sudden Gradual
Constant Intermittent

When does pain occur?

Upon Walking On Standing
During Walking Lying in Bed
After Walking Spontaneously
During work Fancier Shoes
After Work Always Present
On Contact Comes & Goes

Duration

< than 1 week >6 months
1 to 2 weeks >1 year
1 Month >3 years
1 to 3 months >5 years
>3 months Always

Other Complaints

Legs _____
Knees _____
Hips _____
Back _____
Usage _____

Sports and Activities

Tennis Walking
Squash Gardening
Racquetball Dancing
Badminton Skating
Cycling Skiing
Exercises Aerobics
Swimming Running
Golf Other _____

Allergies

Aspirin _____
Cortisone _____
Sulphas _____
Codeine _____
Novocaine _____
Penicillin _____
Erythro. _____
Tape _____
Other _____

Medications: Please list
