

ALLISTON FOOT & ORTHOTIC CLINIC | PATIENT IDENTIFICATION & MEDICAL HISTORY FORM

Please complete all applicable sections. If something does not apply, Indicate "No" or "None"

PATIENT INFORMATION

LEGAL NAME: _____ DATE OF BIRTH: _____
(mm/dd/yyyy)

PREFERRED NAME: _____ PRONOUNS: _____

ADDRESS: _____ POSTAL CODE: _____ CITY/TOWN: _____

PREFERRED PHONE: _____ EMAIL: _____
(Circle): Cell Home

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

FAMILY DOCTOR: _____ LOCATION (CITY/TOWN): _____

WHAT IS YOUR PREFERRED PHARMACY?

Some conditions may be treated with prescription medications, including oral or topical medications. Please provide the pharmacy name and location you would like us to use if a prescription is required.

PHARMACY: _____ LOCATION (CITY/TOWN): _____

INSURANCE INFORMATION

Provide information for your primary insurance plan.

INSURANCE COMPANY: _____ POLICY HOLDER: _____

RELATIONSHIP TO INSURER: _____ POLICY HOLDER DATE OF BIRTH: _____

POLICY #: _____ PLAN #: _____

YOUR CURRENT CONCERN & TREATMENT HISTORY

Please describe the specific foot concern that brings you in today, including where it is located, what symptoms you are experiencing, and how long it has been bothering you.

Have you tried any treatments for this concern before today? – Please tell us where or by whom you were treated (e.g. Chiropractor, Orthopedic Surgeon, Physiotherapist, Chiropractor, Family Doctor, Specialist, Osteopath, home treatment), what treatment you received, and whether it helped.

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MEDICAL HISTORY

Our practitioners may prescribe oral or topical medications and provide treatments that can interact with your current medications. An accurate and complete medication list helps us identify potential contraindications, drug interactions, and adverse reactions and provide you with safe, appropriate care.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING OR TAKING.

☐ PROVIDED A LIST OF MEDICATIONS

This includes prescription medications, over-the-counter (OTC) medications, vitamins/supplements, birth control, blood thinners, aspirin, injections, inhalers, medicated creams/ointments, patches, eye drops, and any medications used only as needed. If you are not currently taking or using any medications. If this does not apply to you, please indicate "No."

DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES?

Please list all medication, material/adhesive, latex, food, and environmental allergies, including the reaction you experience. If this does not apply to you, please indicate "No."

HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC OR INJECTION?

☐ YES ☐ NO

HAVE YOU EVER HAD ANY SURGERIES?

Please list all previous surgeries, even if they seem unrelated to your feet, as your surgical history may be important to your overall health and foot care. If this does not apply to you, please indicate "No."

HAVE YOU EVER BROKEN OR FRACTURED A BONE?

Please list all previous fractures, even if they seem unrelated to your feet, as they may be relevant to your overall health and foot care. If this does not apply to you, please indicate "No."

HAVE YOU EXPERIENCED PREVIOUS OR ONGOING ANKLE SPRAINS, ANKLE INJURIES, OR ANKLE WEAKNESS/INSTABILITY?

☐ YES ☐ NO

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REVIEW OF SYSTEMS

Have you ever been diagnosed with or treated for any of the following conditions? Please check all that apply.

- | | |
|--|---|
| ☐ Heart or circulation condition: heart attack, angina, heart failure, arrhythmia, pacemaker, valve disease, high or low blood pressure | ☐ Back condition, spinal stenosis or sciatica |
| ☐ Stroke or transient ischemic attack | ☐ Asthma, COPD, Emphysema or other breathing condition |
| ☐ Blood clot, peripheral arterial disease, varicose veins, chronic swelling or lymphedema | ☐ Cancer: Where? _____ When? _____ |
| ☐ Bleeding or clotting disorder | ☐ Immune-system condition, HIV, or immunosuppressive treatment |
| ☐ Kidney disease | ☐ Skin condition: psoriasis, eczema, chronic rash or poor wound healing |
| ☐ Thyroid or other endocrine condition | ☐ Stomach or bowel condition: ulcer, reflux, Crohn disease, ulcerative colitis or other |
| ☐ Arthritis: osteoarthritis, rheumatoid, psoriatic or other inflammatory arthritis | ☐ Anxiety, depression, claustrophobia, neurodevelopmental condition or another condition that may affect comfort or care |
| ☐ Gout | ☐ Pregnant, possibly pregnant, recently postpartum or breastfeeding |
| ☐ Osteoporosis or osteopenia | ☐ Other condition not listed |
| ☐ Neurologic or neuromuscular condition: neuropathy, seizures, multiple sclerosis, muscular dystrophy, cerebral palsy, spinal cord condition or other | ☐ None of the above |

Please provide details about any conditions or symptoms you selected above, including any relevant diagnoses, treatments, or ongoing concerns. If this does not apply to you, please indicate "No."

HEALTH HABITS

Nicotine and excessive alcohol use can affect circulation, nerve health and healing, increasing the risk of wounds, infection and, in severe cases, amputation of lower legs and feet.

Alcohol Use: This information is asked as part of your medical history and may be relevant to your circulation, nerve health, medications, and treatment. Which best describes your usual alcohol use?

- | | |
|---|--|
| ☐ I do not drink alcohol | ☐ 4 or more days per week |
| ☐ Occasionally (less than once per week) | ☐ Prefer not to answer |
| ☐ 1–3 days per week | |

Nicotine Use: This information is part of your medical history and may be relevant to circulation, healing, and your overall foot health. Which best describes your current nicotine use?

- | | |
|---|---|
| ☐ I do not use nicotine products | ☐ I use other nicotine products |
| ☐ I smoke cigarettes | ☐ I previously used nicotine but have quit |
| ☐ I vape nicotine | ☐ Prefer not to answer |

DIABETES SCREENING & FOOT HEALTH

Have you ever been diagnosed with Diabetes?

If you do not have diabetes, please indicate below then skip the diabetes and foot screening questions and continue to the **Lifestyle & Activity Section**. If you have diabetes, please complete all screening questions to help us assess your foot health and provide safe, appropriate care.

- | | |
|---|--|
| ☐ No | ☐ Type 2 Diabetes (Diet-Controlled, Non-Insulin-Dependent, Adult Onset) |
| ☐ Prediabetes (Borderline) | ☐ Gestational Diabetes |
| ☐ Type 1 Diabetes (Insulin-Dependent IDDM, Juvenile) | |

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YOUR DIABETES HISTORY

Year Diagnosed: _____ Value of your most recent A1C and date, if known: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING IN YOUR FEET OR TOES? *Select all that apply.*

- | | |
|---|--|
| ☐ Numbness or reduced feeling | ☐ Unusual sensitivity or pain from light touch, sock or bedsheets |
| ☐ Tingling or pin and needles | ☐ Difficulty feeling temperature or telling hot from cold |
| ☐ Burning | ☐ Weakness, unsteadiness or balance problems |
| ☐ Sharp, shooting, stabbing or electric shock pain | ☐ None of the above |

Have you ever had a toe, foot, or lower-leg amputation, ulcer, wound, or infection? *Please include any current, recent, or previous concerns and provide details if applicable.* ☐ YES ☐ NO

LIFESTYLE & ACTIVITY

Your height, weight, occupation, activity level and usual footwear can directly affect your foot health and treatment. This information helps us assess weight distribution, physical demands, footwear needs, treatment planning and safe medication/freezing dosages.

What is your approximate height? _____

What is your approximate weight? _____

What is your shoe size? _____

Has your weight changed significantly in the past 6 months?

- | | | |
|--|---|---|
| ☐ No significant change | ☐ Yes – I have gained weight | ☐ Yes – I have lost weight |
|--|---|---|

Employment Status

- | | | |
|------------------------------------|-------------------------------------|---------------------------------------|
| ☐ Full-Time | ☐ Occasional | ☐ Retired |
| ☐ Part-Time | ☐ Home | ☐ Student |
| | | ☐ Other: _____ |

Typical Daily Standing & Walking

- | | |
|--|---|
| ☐ Less than 2 hours | ☐ 8–10 hours |
| ☐ 2–4 hours | ☐ 10–12 hours |
| ☐ 4–6 hours | ☐ More than 12 hours |
| ☐ 6–8 hours | |

What sports, exercise, or physical activities do you regularly participate in? *Please include activities such as walking or running, how often/how far you participate, and whether they are seasonal or year-round.*

What type of footwear do you wear most often?

- | | | |
|--|--|--------------------------------|
| ☐ Work boots | ☐ Heels | ☐ Crocs |
| ☐ Running Shoes | ☐ Walking Shoes | ☐ Other |
| ☐ Slip-ons | ☐ Sandals | |
| ☐ Flats | ☐ Laced | |

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Please complete all applicable sections. If something does not apply, Indicate "No" or "None"

Do you wear footwear inside the house? *If YES, please indicate the type. Slippers, Sandals, Running Shoes, etc.*

Who usually provides your routine foot and/or nail care? *Please check all that apply.*

- | | | |
|--|--|---|
| ☐ I care for my own feet/toenails | ☐ Pedicurist/nail salon | ☐ Chiropodist/podiatrist |
| ☐ Family member or caregiver | ☐ Foot care nurse | ☐ Other: _____ |

Have you ever tried arch supports or orthotics? *Select all that apply.*

Over-the-counter (store-bought) arch supports. ☐ Yes ☐ No

If yes, did they help? Please briefly explain:

Custom-made orthotics. ☐ Yes ☐ No

If yes, did they help? Please briefly explain:

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COMMUNICATION

Appointment Notifications Office Clinic Updates

EMAIL

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Receive our monthly newsletter and important clinic updates, including hours, fees, access, cancellations and waitlist openings. We never sell or share your email, and you can unsubscribe anytime.

- ☐ I would like to receive all email communications.
- ☐ I would like to only receive email notifications of new, cancelled, and rescheduled appointments
- ☐ I do not want to receive any e-mails.

TEXT MESSAGE (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- ☐ Text Message (SMS) 2 days before appointment
- ☐ Text Message (SMS) 1 hour before appointment

PRIVACY AND PERSONAL HEALTH INFORMATION

Alliston Foot & Orthotic Clinic collects, uses, stores and protects personal and health information in accordance with Ontario's Personal Health Information Protection Act (PHIPA), PIPEDA where applicable, and professional requirements.

We collect only the information reasonably necessary to:

- Identify you and maintain an accurate health record
- Assess, provide, coordinate and document your care
- Communicate about appointments, treatment and follow-up
- Process payments, receipts and authorized insurance documents
- Operate the clinic and meet legal, regulatory and record-keeping requirements

Your information may be accessed by your treating practitioner, authorized clinic staff and service providers who require it to perform their duties. Appropriate physical, administrative and electronic safeguards are used to protect your information. Unless you tell us otherwise, relevant information may be shared with health-care providers within your circle of care, such as your physician, nurse practitioner, pharmacist, specialist, laboratory or other treating provider, when reasonably necessary to provide or coordinate your care.

Except where permitted or required by law, we will obtain separate express consent before disclosing your information to someone outside your circle of care, such as an insurer, employer, lawyer, school or other third party.

The clinic may use authorized electronic systems and service providers, including Jane, secure communication services, payment processors, laboratories and orthotic laboratories. Although reasonable safeguards are used, no electronic system or communication method can be guaranteed to be completely risk-free.

You may request access to or correction of your health record, ask questions about our privacy practices, restrict certain disclosures, or withdraw consent. Withdrawal is not retroactive and may be subject to legal, professional or record-retention requirements. If a restriction could affect our ability to provide safe care, we will explain this to you.

Privacy decisions are based on capacity rather than age alone. Where a patient is not capable of making a particular privacy decision, consent will be obtained from the legally authorized substitute decision-maker.

I have read or had this privacy information explained to me. I understand how my information may be collected, used and shared for my care and clinic operations. I understand that I may ask questions, request access or correction, restrict certain disclosures, or withdraw consent subject to legal limitations. I understand that this acknowledgement is not blanket consent to treatment or to unrelated third-party disclosures.



I have read or had this privacy information explained to me. I understand how my information may be collected, used and shared for my care and clinic operations. I understand that I may ask questions, request access or correction, restrict certain disclosures, or withdraw consent subject to legal limitations.

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ASSESSMENT AND TREATMENT CONSENT

During your visit, the chiroprapist may review your health history, medications, allergies and current concerns and perform an appropriate assessment of your feet, ankles or lower limbs.

After the assessment, the chiroprapist will explain any recommended treatment before it begins. This discussion will include the nature and purpose of the treatment, its expected benefits, material risks and possible side effects, reasonable alternatives, the likely consequences of not proceeding, and the applicable fees.

You will have an opportunity to ask questions before deciding whether to proceed. You may accept or refuse any recommendation and may withdraw your consent at any time.

Attending the clinic for an assessment does not mean that you have agreed to every treatment that may be recommended. Treatment will begin only after it has been explained and you have agreed to proceed. Separate consent may be required for procedures involving additional or more complex risks, including surgery, injections, custom orthotics, shockwave therapy or other invasive procedures.

 Initials

☐

I confirm that I have read and understand the information above, including my right to ask questions refuse a recommended treatment or withdraw consent at any time.

CLINIC FEES AND MISSED APPOINTMENT FEES

Chiropody Services in Ontario are not covered by OHIP, but are covered by most Third Party Insurance, Extended Health Care Plans & Veterans' Affairs, and/or can be used for income tax health deduction purposes. Chiroprapists and Podiatrists are the ONLY recognized Foot Specialists in Ontario.

Not all fees are displayed but would be discussed on an individual basis as needed. The fee guide is based on the Ontario Society of Chiroprapists and the Canadian Federation of Foot Specialists and is determined by:

- the time requirement to perform the service
- the level of skill required to perform the service
- the cost associated to perform the service
- the education level and training required to perform the service
- the level of risk associated with performing the service

FEE STRUCTURE

\$90 Initial Visit & Assessment/ Re-Assessment	\$75 Foot Pain Assessment	\$500 Total Nail avulsion
Up to \$75 Return Visit / Nail Care, Callous & Corns	\$50 Wound Care/Examination	\$400-600 Tendon/Neuroma
\$75.00 Ingrown Toenail Care	Up to \$75 Plantar Warts/Fibrous Corns	\$550 Custom made Orthotics
	\$400 Partial Nail avulsion	

CUSTOM ORTHOTICS AND PRODUCTS

Custom orthotics are individually prescribed and manufactured medical devices. Once fabrication has begun, they cannot be returned or refunded. The orthotic fee, included services, adjustment period, deposit requirements and any additional costs will be explained before the order is placed.

PAYMENT AND INSURANCE

- Payment is due when the service or product is provided unless another arrangement has been approved in advance.
- Accepted payment methods are cash, debit, credit card and e-transfer.
- You are responsible for confirming your insurance coverage, referral requirements and claim limits.
- Insurance reimbursement is not guaranteed.
- You remain responsible for the clinic fee if your insurer denies or reduces your claim.
- An itemized receipt will be provided at no additional charge.
- The clinic cannot alter dates, diagnoses, service descriptions, practitioner information or fees for insurance purposes.
- Fees may be updated periodically. The current applicable fee will be disclosed before the service or product is provided.

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MISSED APPOINTMENTS AND LATE CANCELLATIONS

Your appointment time is reserved specifically for you.

At least 24 hours' notice is required to cancel or reschedule an appointment. Appointments cancelled or rescheduled with less than 24 hours' notice, and appointments that are missed without notice, may be charged the full fee for the appointment that was reserved.

The clinic may consider emergencies or exceptional circumstances when deciding whether to apply the fee.

LATE ARRIVALS

Arriving late may reduce the time available for your appointment. Depending on the remaining time and the care required, the clinic may provide a shortened appointment where clinically appropriate or reschedule the visit.

Treatment will not be rushed when there is insufficient time to provide it safely. If the appointment must be rescheduled because of a late arrival, the missed-appointment fee may apply.

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I confirm that I have reviewed the clinic's current fee structure and understand my responsibility for payment, regardless of insurance reimbursement. I understand that an appointment cancelled, rescheduled or missed with less than 24 hours' notice may be charged the full fee for the appointment reserved.

SOCIAL MEDIA AND ONLINE COMMUNICATION POLICY

Alliston Foot & Orthotic Clinic uses social media to share general clinic information, foot-health education, service updates and announcements. Social media is public and is not a secure or appropriate way to communicate about your health care.

CONTACTING THE CLINIC

Please do not use Facebook Messenger, Instagram, LinkedIn or comments on social-media posts to:

- Book, cancel or reschedule an appointment;
- Ask a medical question;
- Send photographs of a health concern;
- Request a prescription, referral or health record;
- Discuss treatment, billing or insurance; or
- Share personal or health information.

The clinic does not routinely monitor social media for urgent messages. For appointments or clinical questions, contact the clinic by telephone, approved email, secure Jane communication or online booking.

Social media and email should not be used for emergencies. If you require urgent medical attention, contact an appropriate emergency service or attend the nearest emergency department.

PROTECTING YOUR PRIVACY

Following, liking, commenting on, reviewing, tagging or sharing the clinic's social-media content is voluntary. These activities may reveal your connection with the clinic to other people.

Clinic staff will not discuss your care, confirm that you are a patient or respond to personal health information posted publicly. We may ask you to contact the clinic privately through an approved communication method.

For privacy reasons, clinic practitioners and staff do not accept personal friend, follower or connection requests from current or former patients through their personal social-media accounts.

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I confirm that I have read and understand the clinic's Social Media and Online Communication Policy, including that social media should not be used for appointments, clinical questions, emergencies or sharing personal health information.

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CLINICAL PHOTOGRAPHS

When clinically appropriate, the practitioner may recommend taking photographs of my feet or lower limbs to:

- Document my condition;
- Support assessment, diagnosis and treatment planning;
- Monitor healing, changes or treatment outcomes;
- Compare my condition before and after treatment; or
- Communicate relevant findings to another health-care provider involved in my care.

Clinical photographs form part of my personal health information and will be stored and protected with my health record.

The practitioner will advise me when a clinical photograph is being taken and explain its purpose. I may ask questions or raise concerns before the photograph is taken.

If I decline a photograph that the practitioner believes is necessary for safe care, accurate monitoring or professional documentation, the practitioner will explain the possible consequences and whether the assessment or treatment can reasonably proceed without it.

OPTIONAL DE-IDENTIFIED USE

The clinic may request permission to use de-identified photographs for:

- Patient or professional education;
- Presentations or teaching materials;
- Clinic information and printed materials;
- The clinic website or social-media pages; or
- Advertising or promotion of clinic services.

For de-identified use, the clinic will not include my name, face, date of birth, contact information or other direct identifiers.

Where possible, tattoos, distinctive markings and other identifying features will be excluded or obscured.

I understand that complete anonymity cannot be guaranteed. Someone familiar with my condition or image may still recognize it. Publicly posted images may also be copied, downloaded, shared or reposted by others. My decision about optional use will not affect my care.

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I acknowledge that I have read and understand the clinic's use of photographs for clinical documentation and my health record. YES, I PERMIT THE CLINIC TO USE DE-IDENTIFIED PHOTOGRAPHS OF MY FEET OR LOWER LIMBS FOR THE PURPOSES DESCRIBED ABOVE. I may withdraw permission for future non-clinical use by contacting the clinic. Withdrawal will not affect material already lawfully published, printed, distributed, downloaded or shared.

☐

I acknowledge that I have read and understand the clinic's use of photographs for clinical documentation and my health record. NO, I DO NOT PERMIT MY PHOTOGRAPHS TO BE USED FOR EDUCATION, SOCIAL MEDIA, THE CLINIC WEBSITE OR ADVERTISING.

AI SCRIBE CONSENT

With your permission, the clinic may use Jane AI Scribe to audio-record the conversation during your appointment and create a draft clinical note.

AI Scribe allows the practitioner to focus more fully on the appointment and reduces the time required for charting. It may also help the clinic:

- Create a more detailed record of the visit;
- Prepare a brief summary of advice and information discussed;
- Document home-care instructions; and
- Prepare correspondence to your physician or another health-care provider when clinically appropriate and authorized.

Your practitioner will review, correct and approve all AI-generated information before it becomes part of your health record or is shared with another health-care provider.

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Jane states that recordings and transcripts are stored securely and are not used to train AI models. The clinic's recordings are deleted from its Jane account after seven days. Jane states that a secure backup copy may remain for up to one additional week before permanent deletion.

Using AI Scribe is optional. You may ask that the recording be paused or stopped and may withdraw your consent at any time. Declining AI Scribe will not affect the assessment or treatment you receive.

If you decline AI Scribe:

- The practitioner will document your visit using the clinic's usual charting process;
- You are welcome to take your own notes or bring a support person where appropriate;
- The clinic will provide written instructions when they are clinically necessary for safe treatment or aftercare; and
- A requested formal report, letter, form or detailed written summary is a separate administrative service and may be subject to the clinic's current report or form-completion fee.

 Initials

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Yes, I consent to the use of Jane AI Scribe during my appointments. This consent is in effect until I withdraw.

 Initials

☐

No, I do not consent to the use of Jane AI Scribe during my appointments.

YOUR INSURANCE POLICY

Direct Billing & Insurance

For your convenience, Alliston Foot & Orthotic Clinic offers direct billing to participating insurance companies when available. Please note that direct billing is a courtesy and does not guarantee that your insurance provider will approve or pay your claim. Insurance coverage varies by plan, and it is the patient's responsibility to understand and confirm their individual coverage, eligibility, limits, deductibles, and requirements.

Payment at Your Appointment

If your insurance provider pays only a portion of your claim, you are responsible for paying the remaining balance at the time of your appointment. If a claim is denied, placed on hold, pending review, cannot be processed electronically, or your insurer requests additional information, you will be required to pay the full outstanding balance at the end of your visit. You may then submit the claim to your insurance provider for reimbursement, where applicable.

Services That May Not Be Eligible for Direct Billing

Not all services or products can be submitted through electronic direct billing. Depending on your insurer and individual plan, this may include:

Custom orthotics and certain medical devices or supplies
Surgical procedures, including ingrown toenail procedures
Services requiring pre-authorization, prescriptions, medical documentation, or additional supporting documents
Claims that an insurer requires the patient to submit directly
Services or products that are not eligible for electronic submission under your specific benefit plan
In these situations, payment may be required directly from the patient and a detailed receipt will be provided for submission to their insurer.

 Initials

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I have insurance: I authorize Alliston Foot & Orthotic Clinic to submit eligible insurance claims on my behalf. I understand that direct billing does not guarantee coverage and agree to pay any balance not paid by my insurance provider.

 Initials

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I do not have insurance: I confirm that I do not have extended health insurance coverage and understand that I am responsible for payment of my clinic fees.

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PATIENT/GUARDIAN DECLARATION

I confirm that the information I have provided on this form is complete and accurate to the best of my knowledge and I will notify the clinic of any changes to my health or personal information.

Patient Name: _____

Signature: _____

Date: _____

If completed by a parent/guardian/substitute decision-maker:

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____