Alliston Foot & Orthotic Clinic

Patient Identification & Medical History Form

Name:_____ Date of Birth: _____
(mm/dd/yyyy)

Address: _____ City:_____

Postal Code:_____ Email : _____
email will be used by us only and to confirm appointments

Telephone:_____ _____ _____
Home Cell Work

Preferred Contact Method (circle): Home / Cell / Work / Email

Family Doctor's Name: _____ City:_____ Phone# _____

Insurance Company:_____ Policy #:_____ Plan ID#_____

Policy Holder Member Name:_____ D.O.B_____

In Case of Emergency, we should notify:

Name:_____ Phone#:_____ Relationship:_____

How did you hear about our clinic?

□ Physician □ Location/Walk-by □ Family-Friend □ Other Health Care Provider
□ Website □ Facebook/Social Media □ Newspaper □ Other:_____

What brings you to see us today?_____

_____

Are you taking any medications, non-prescription drugs of any kind? If ☐ YES , please list or provide copy. ☐ **NO**

_____

_____

Do you take any blood thinners? Aspirin or others ☐ **YES** ☐ **NO** Do you take birth control medications? ☐ **YES** ☐ **NO**

Do you have any ALLERGIES? ☐ **NO** **If ☐ YES, please list:**

□ Aspirin □ Codeine □ Ibuprofen/NSAIDs □ Sulfa □ Local Anesthetic
□ Penicillin □ Steroids □ Adhesives/tape □ Iodine □ Elastoplasts
□ Latex □ Other:_____ □ Type of reaction _____

Do you have or have you ever been diagnosed with any of the following? ☐ **NO**

□ **Diabetes:** Year Diagnosed:_____
□ Insulin Dependent Type 1
□ Non Insulin Dependent Type 2
□ Diet Controlled- Borderline
Last A1C test:_____ Control Level: □ poor □ good □ great

□ **Arthritis** Joints Affected:_____
□ Osteo
□ Rheumatoid
□ Psoriatic

□ **Heart Attack** year:_____ □ **Stroke** year:_____ side affected:_____

□ **Angina/Chest Pain: Nitroglycerine use**: □ **NO** □ **YES** Where do you carry it?_____

I have provided up-to-date information and will advise of any changes in my personal and medical information at each visit.

Signature Patient/Guardian: _____ **Date:**_____

Alliston Foot & Orthotic Clinic
Medical History and Foot Examination

Initial / Re-Assessment

Name: _____ Date: _____

Review of Systems

□ Kidney disease
□ Liver disease
□ Thyroid disease
□ Osteoporosis/ Osteopenia
□ Asthma – COPD - Emphysema
□ Psoriasis – Eczema - Rash/skin problem
□ Blood Clots - Varicose veins
□ High/Low blood pressure
□ Congestive Heart Failure
□ Pacemaker – Irregular heart arrhythmia
□ Mitro-valve prolapsed – valve replaced
□ Gout
□ Muscular Dystrophy – Multiple Sclerosis
□ Fibromyalgia
□ Anxiety – Depression – Claustrophobia
□ Spina bifida – Cerebral Palsy
□ Spinal Stenosis
□ HIV/AIDS - Hepatitis A/B/C
□ Seizures - Epilepsy
□ Bleeding Disorders
□ Stomach Ulcer - Acid Reflux - Crohn's / Colitis
□ Pregnancy
□ Cancer
□ Other:_____

Surgeries:_____

Fractures/Broken Bones:_____ Any past ankle sprains? □ YES □ NO

NOTES: _____

Employment Status
□ Not Working: Home/Retired/Disable/Student
□ Occupation_____
□ Full time □Part-time □ Occasional

%typical day:
Standing_____%
Walking_____%
Sitting_____%

Sport & Activities. List:
_____
_____
□ Summer □ Winter □ All the time
Times/Week_____ Min/Km:_____

Physical Attributes
Height _____ Weight_____Shoe Size_____
Past 6 months any weight □ gain □ loss How much?_____
#___childbirths. Are you currently pregnant? □ Yes □ No

Footwear
What type of shoes worn most of the time?_____
□Work boots □ Running shoes □ Slip-ons
□Flats □ Heels ___" □ Walking shoes
□ Sandals □ Laced □ Other:
What do you wear inside the house?_____

Social History

Alcohol Usage: □ Yes □ No □ Previous Use **Cigarette/Tobacco Use**: □ Yes □ No □ Previous Use

Foot History & Information

Any Family members who have had: Diabetes_____ Foot Problem_____

Have you ever had your feet examined before by a:
□ Family physician □ Chiropodist/Podiatrist □ Orthopedic Surgeon □ Pedicurist □ Other:_____

Did you previously or do you now wear:
Over the counter insert? □ Yes □ No Still using them? □ Yes □ No Do or did they help? □ Yes □ No
Custom made orthotics? □ Yes □ No Still using them? □ Yes □ No Do or did they help? □ Yes □ No
The orthotics were obtained (year)_____ from (practitioner) _____

Diabetes, Neurological & Vascular Foot Screening:
Do you ever get calf or leg cramps? □ No □ Yes. When? Day while walking OR Night time/Rest/Sleeping
Do you feel your feet are cold or hot? □ Yes □ No
Are your feet or toes ever numb? □ Yes □ No
Do they ever tingle? □ Yes □ No
Do they ever burn? □ Yes □ No
Or feel like insects are crawling on them? □ Yes □ No

NOTES: _____

Assistant: _____

Alliston Foot & Orthotic Clinic

Sonia Maragoni, D.Ch., B.H.A., B.Sc. Podiatric Medicine
Chiropodist – Foot Specialist
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Welcome to the Alliston Foot & Orthotic Clinic! 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. Chiropodists 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 Chiropodists 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

Initial Visit / Re-Assessment / Examination / Treatment			**$75-90**
Return Visit / Examination / Treatment			**$50-65**
Extended Visit / Examination / Treatment			**$10- 20**
Emergency Visit (plus additional cost of visit)			**$50**
Plantar Warts / Verrucae Treatment			**$50-60**
Shockwave Therapy (Per Treatment)			**$75**
Local Anesthetic Injection (plus additional cost of visit)			**$40**
Cortisone Injection (plus additional cost of visit)			**$40**
Orthotics	**Custom made orthotics case fee**		**$475**
	Rush Order Requests (72 Hours)		**$50**
	Includes the biomechanical assessment, gait analysis, Casting/3D Scanning one pair of orthotics, fitting, review and adjustments within 3 months		
Orthotics Review/Repair Adjustments/Recovering after 6 months			**$75-125**
Shoe Padding / Alterations			**$25**
Surgery	**Nails:**	**Partial nail avulsion**	**$350**
		Total nail avulsion	**$400**
		For additional toes at same time	**$150**
	Soft Tissue – Tendon/Neuroma		**$275-550**
Cancellation/Tardiness/No Show Fee			**$25**

We require 24 hours notification for cancellation of an appointment or a fee of $25 will be charged for your missed, tardiness or last minute cancellation.

****Payment in full is required after treatment**** **Prices may be subject to a yearly increase**

I understand and agree to the above fee structure and hereby authorize the Chiropodist in charge to perform treatment on myself as explained to me by the Chiropodist.

Signature of Patient or Guardian Date