**New Patient Intake Form & Consent**

**Please fill out the following forms**

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| --- |
|   FIRST NAME:                                                    LAST NAME:  |
|   Date of Birth (DD/MM/YY):  |   SEX   ☐ M     ☐ F     ☐ Other |
|   Address:                                                                                    City/Province:                                                                           Postal code:  |
|   Home Phone:  |  Cell Phone:  |
|   Occupation:  |  Work phone:  |
|   Email address:  |
|     Guardian’s Name (if applicable):     Relationship:   |  In case of emergency who should we call? Name: Relationship: Phone#:  |

|  |  |
| --- | --- |
|   Family Physician:  Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   Phone #:  |
|   Address:  |
|   Do you want us to update your family doctor if we find any major issue?      ☐ YES      ☐ NO |
|   Name of Health Insurer:  |
| HOW DID YOU HEAR ABOUT US?  ☐ WEBSITE                                  ☐ WORD OF MOUTH                                         ☐ SOCIAL MEDIA ☐ MY FAMILY DOCTOR              ☐ OTHER (please specify):  |

**Do you have any of the Following Conditions?** (**Check all that Apply)**

|  |
| --- |
| ☐ Type 1 Diabetes ☐ Kidney Disease ☐ Liver Disease ☐ Osteoporosis ☐ Arthritis ☐ Type 2 Diabetes        ☐ Cancer ☐ Hepatitis ☐ HIV/AIDS   ☐ Epilepsy ☐ Gout            ☐ Asthma ☐ COPD ☐ Thyroid issues ☐ Stroke ☐ Psoriasis/Eczema      ☐ High blood pressure ☐ High Cholesterol ☐ Varicose Veins ☐ Smoker ☐ Poor circulation ☐ Congestive heart failure ☐ Heart attack ☐ Psychological Disorder ☐ MS  ☐Other: ☐ Surgeries:  |

**New Patient Intake Form & Consent Cont’d**

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| **Please List Current Medications:**Do you take Aspirin, Coumadin or other blood thinners?     ☐Yes         ☐No**Allergies:**   ☐ ADHESIVE TAPE                                ☐ Latex                        ☐ LOCAL ANAESTHETICS                            ☐ ANTIBIOTICS (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                          ☐ OTHER (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   **What brings you in to see us today?** **How long have you had this problem?****Have you been examined for it by**  ☐ Family Doctor     ☐ Chiropodist/Podiatrist     ☐ Others:   **Have you done any treatment for it?** (if yes, specify):           **If you have foot pain, how do you rate the pain today**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

 |  |
|  Weight:                                       Height:                                          Shoe Size:                     |  |

**Informed Consent for Foot Examination and Treatment**

Chiropodists are required to advise patients of the general risks associated with common services and obtain consent for assessment and treatment prior to initiation of services. Consents will be updated annually to ensure compliance with College of Chiropodists of Ontario documentation requirements.

The chiropodist will assess your current foot condition and evaluate your individual risk factors; taking medical conditions, overall health, and activity level into account. A management plan will be presented to you based on that assessment.

Verbal consent will be obtained on an ongoing basis for routine care and services. Treatments will only be initiated after expressed verbal consent. Consent will include disclosure of costs associated with treatments, products, and devices prior to their delivery.

**Potential Risks and Discomforts Associated with Chiropody Foot Care Treatments:**

Chiropodists are highly skilled and perform foot care daily. Some treatments will involve the use of sharp instruments (nail cutting, callus and corn debridement, wart debridement etc.). There is a small risk of discomfort during these procedures, including bleeding points which are rare but sometimes unavoidable. Treatment will include management to prevent complications and infection control protocols are in place to protect patients.

**Custom Foot Orthotics**

Custom Orthotics may be recommended for your care. As a custom made product, these devices are non-refundable. Orthotics case fee include biomechanical assessment and gait analysis, fitting and dispensing appointments, and follow up appointments that may involve adjustment and modification to ensure best outcomes. The orthotics’ optimal function depends on having a proper stable base; **supportive deep footwear** will provide better function. Slimmer orthotics can help maintaining wellness in dressier shoes, but rarely provide the ideal prognosis for improvement. It is recommended to replace shoes with obvious signs of wear to get best results with your orthotic therapy. In all cases, your optimal management plan will be presented for your consideration and consent. If you are unable to accept the management plan, alternatives will be presented with a description of their expected level of success/efficacy.

**Photographs**

Occasionally, photographs of your feet will be taken with your ongoing verbal consent for the following purposes:

 Documenting initial foot condition

 Documenting treatment (before/after)

 Monitoring your foot condition and evaluating treatment success

 Educational purposes on social media and clinic’s website (Non-identifying images ONLY)

Our Privacy Policy is in compliance with the protocols and standards set by Ontario College of Chiropodists. Our office is committed to the highest standards of Chiropody and Podiatry Medicine.

If the chiropodist recognizes that the patient is not capable to give an informed consent, the legal guardian of the patient must sign the form and needs to accompany the patient during the appointment/treatment time.

**Patient’s Name: Date of Birth:**

**Signature: Date of Consent:**

**Witness: Treating Chiropodist:**