HUNT FOOTCARE

☐ London Foot Specialists
279 Wharncliffe Road North
Suite 108, London ON, N6H 2C2
Tel: (519) 432 3636

☐ Stratford Foot & Ankle Clinic
502 Huron Street
Stratford, ON, N5A 5T7
Tel: 519-271-8834

☐ Ingersoll Foot & Ankle Clinic
238 Thames Street South,
Ingersoll, ON, N5C 2T5
Tel: (519) 485-1750

PATIENT INFORMATION

Welcome to our Practice

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other _____

☐ Male ☐ Female

Patient First Name _____ Middle Name _____ Last Name _____

Patient Home Street Address _____ Apt# _____

City _____ Province _____ Postal Code _____

Patient Home Phone# [ ] _____ Cell Phone# [ ] _____ Work# [ ] _____

Patient Date of Birth _____ / _____ / _____ (Day / Month / Year) Patient Email Address [please print clearly] _____

Name of Family Physician _____ Date of Last Visit _____

Patient Occupation _____ Employer Name _____

Emergency Contact Name _____ Phone _____ Relationship _____

Patient Height _____ Weight _____ Shoe Size _____

Do you currently use orthotics? (shoe inserts) _____

If you have had foot x-rays or diagnostic tests, when were they taken? _____

PREFFERED CONTACT METHOD

☐ Home Phone ☐ Cell Phone ☐ Work ☐ Email

If the patient is a minor (Under 18) - provide name of parents or guardian _____

Address of parents or guardian _____

Phone# [ ] _____ Cell Phone# [ ] _____

REFERRAL INFORMATION

We appreciate your referrals! Whom may we thank for referring you to our office?

Name _____ Address _____

Is this person your: ☐ Family Doctor ☐ Other Specialist ☐ Family Member ☐ Friend

Other Referral Sources [check all that apply and please specify names where indicated]:

Internet Search (name)	Phone Book (name)	Our Practice Website	Newspaper Ad (name)	Saw Our Sign	Insurance Plan Or Website (name)	Other (name)

Please turn over and complete

PODIATRIC HISTORY

Have you ever been to a podiatrist / chiropodist before? ☐ Yes ☐ No

WHAT IS YOUR MAIN FOOT COMPLAINT TODAY?

Your foot problem involves: Right Foot Only ☐ Left Foot Only ☐ Both Feet ☐

When did it begin? _____

Did you receive treatment for this condition? ☐ Yes ☐ No

If so, what type?

Circle the **degree of pain** you are currently experiencing:

Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **foot conditions**?
Please check all that apply:

- ☐ Ankle Instability
- ☐ Arthritis
- ☐ Back Pain
- ☐ Blisters
- ☐ Bone Spurs
- ☐ Bunions
- ☐ Burning Feet
- ☐ Corns/Calluses foot or toes
- ☐ Diabetic Evaluation
- ☐ Flat Feet
- ☐ Fracture (foot/ankle/leg)
- ☐ Fungal Infections (skin/nail)
- ☐ Gout
- ☐ Hammertoes
- ☐ Heel Pain
- ☐ Hip Pain
- ☐ Infections
- ☐ Ingrown Toenails
- ☐ Intoe - Out toe walking
- ☐ Joint Pain
- ☐ Knee Pain
- ☐ Limb Length Discrepancy
- ☐ Neuromas
- ☐ Numbness or tingling in foot or toes
- ☐ Plantar Fasciitis
- ☐ Postural Fatigue
- ☐ Pronation
- ☐ Shin Splints
- ☐ Sprains
- ☐ Sweating/Odor
- ☐ Tendonitis
- ☐ Tired feet
- ☐ Ulcers
- ☐ Warts

MEDICAL HISTORY

Have ever been treated for any the following conditions?

- ☐ Yes ☐ No Acid Reflux
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Bleeding Disorders
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Fibromyalgia
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Heart Condition
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No High Cholesterol
- ☐ Yes ☐ No HIV/Aids
- ☐ Yes ☐ No Hypertension
- ☐ Yes ☐ No Hyperthyroidism
- ☐ Yes ☐ No Hypothyroidism
- ☐ Yes ☐ No Irritable Bowel Syndrome
- ☐ Yes ☐ No Kidney Problems
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Low Blood Pressure
- ☐ Yes ☐ No Nervous Disorder
- ☐ Yes ☐ No Muscle or Joint Pain
- ☐ Yes ☐ No Peripheral Arterial Disease
- ☐ Yes ☐ No Phlebitis
- ☐ Yes ☐ No Poor Circulation
- ☐ Yes ☐ No Respiratory Disease
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Seizure Disorders
- ☐ Yes ☐ No Skin Disorders
- ☐ Yes ☐ No Stomach Ulcers
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Thyroid Problem
- ☐ Yes ☐ No Varicose Veins

MEDICATIONS

Are you curently on Blood Thinners? ☐ Yes ☐ No

Can you provide a printed list of your medications or list them below:

Name of Medication	Strength / Mg	Taken how often?

Do you currently use: Cigarettes or Tobacco? ☐ Yes ☐ No ☐ Quit

If yes, for how long? _____ How many pks/day? _____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Alchohol use? ☐ Yes ☐ No If yes, quantity ____ daily ____ weekly

SURGERIES

Please List All Surgeries	Approximate Date

If other, please explain _____

ALLERGIES

Have you ever had adverse side effects or allergies to:

- ☐ Yes ☐ No Adhesive Tape
- ☐ Yes ☐ No Anticoagulants
- ☐ Yes ☐ No Anti-Inflammatory Medications
- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Codeine
- ☐ Yes ☐ No Cortisone
- ☐ Yes ☐ No Iodine
- ☐ Yes ☐ No Latex
- ☐ Yes ☐ No Metal/Jewelry
- ☐ Yes ☐ No Novacaine
- ☐ Yes ☐ No Peanuts
- ☐ Yes ☐ No Penicillin
- ☐ Yes ☐ No Seafood
- ☐ Yes ☐ No Other Antibiotics
- ☐ Yes ☐ No Other Pain Medication
- ☐ Yes ☐ No Other

If other, please explain _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

☐ I hereby allow and consent to examination and treatment by the Chiropodist and/or staff, and allow photographs of treatment areas to be taken for the purposes of monitoring.

☐ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service fees are payable at the time service is provided.

☐ I hereby state that the above information is true and accurate and give my permission to J. Craig Hunt B.Sc., D.Ch., PgD., to administer treatment and to perform such operative procedures as may be deemed necessary in the diagnosis and/or treatment of mv foot condition.

Patient Signature (or guardian) _____

Date _____