Exceptional footcare for all ages.

Werkman, Boven

& ASSOCIATES | CHIROPODIST

Medical Update Form

Hello again! We're dedicated to providing exceptional foot care for people of all ages. Please help us update your file by providing the following information. If you have any serious medical emergencies, please go to the nearest hospital emergency department.

First Name: ______________________ Last Name: ______________________

Preferred Name: ______________________ Gender (Circle one): Male Female Other Prefer Not to Say

Address: ______________________ City: ______________ Postal Code: __________

Phone (Home): ______________________ Phone (Cell): ______________________

Phone (Work): ______________________ Phone Other: ______________________

Email Address: ______________________ Please indicate below your choice of appointment confirmation:

Date of Birth (D/M/Y): ______________________ ☐ Phone Call ☐ Email ☐ Text Message

Our clinic takes your confidentiality seriously and respects your privacy. Your information is safe and secure with us.

May we use your email address for: ☐ Financial Documents ☐ Appointment Related Correspondence ☐ Newsletter/Other

Your Occupation: ______________________ Employer: ______________________

Emergency Contact Name: ______________________ Relationship: ______________________

Phone (Primary): ______________________

Parent/Guardian Name(s) (if child is under 18): ______________________ ______________________

What is your current:

Height: ______________________

Weight: ______________________

Shoe Size: ______________________

Continued on the other side →

Please answer the following questions:

Do you have or have you ever been treated for:
(Check all that apply)

- ☐ Cardiovascular disease
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Urinary problem
- ☐ Stroke
- ☐ Metabolic disorder
- ☐ Depression
- ☐ High blood pressure
- ☐ Cholesterol
- ☐ Cancer, malignancy, or tumour
- ☐ Shortness of breath
- ☐ Dementia or Alzheimer's
- ☐ Skin disorder
- ☐ Thyroid problem
- ☐ HIV/AIDS
- ☐ Blood disease or disorder
- ☐ Stomach/Bowel trouble
- ☐ Autoimmune disease
- ☐ Anxiety
- ☐ Bone disease
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Endocrine disorder

Diabetic Information:

Diabetes: ☐ Type 1 ☐ Type 2 How long? _______

Have you ever attended a Diabetic clinic? ☐ Yes ☐ No

Have you ever had a Diabetic foot ulcer or infection? ☐ Yes ☐ No

Other medical treatments: ________________________________

____

Please provide your medication record or list your current prescription or OTC medications, home remedies, or recreational drugs: ________________________________

____

____

Do you have any known allergies, sensitivities, or previous reactions to:

Adhesive tape/band-aids? ☐ Yes ☐ No

Latex? ☐ Yes ☐ No

Local anesthetics? ☐ Yes ☐ No

Medications? ☐ Yes ☐ No

Please specify medications:________________________________

____

Other allergies: ________________________________

____

Are you slow to heal after cuts? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Are you currently pregnant or nursing? ☐ Yes ☐ No

Physicians & Medical Specialists

Family Physician: ________________________________

Phone: ________________________

Has your doctor treated your foot condition? ☐ Yes ☐ No

Did this doctor refer you to us? ☐ Yes ☐ No

Medical Specialist: ________________________________

Phone: ________________________

Did this specialist refer you to us? ☐ Yes ☐ No

Do you have any ongoing investigations? ☐ Yes ☐ No

Please specify: ________________________________

____

Patient's Consent

Please check all the agreed conditions.

Please refer to our website for additional information and Patient Policies.

☐ I hereby consent/allow to examination and treatment including various modes of physical therapy, by the Chiropodist and/or support staff, also to allow photographs of treatment areas to be taken for the purposes of monitoring.

☐ I consent/allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information.

☐ I consent/allow the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.

☐ I further understand and am informed that, as in all health care, in the practice of chiropody, there are some very slight risks to treatment including, but not limited to pain, swelling and infection. I do not expect the Chiropodist to be able to anticipate and explain all the risks and complications. I wish to rely on the Chiropodist's judgment regarding my appointment and care.

☐ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not and are payable at the time service is provided. You will be notified of additional fees prior to treatment.

Patient's signature (or guardian): ________________________ Date: ________________

We promise to treat your personal information with respect. Our privacy protocols comply with privacy legislation, the standards of the College of Chiropodists of Ontario and the law. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.

We require at least 48 hours' notice to cancel or reschedule an appointment. The appointment fee will be applied for appointments cancelled with less than 48 hours' notice or a missed appointment. All fees for cancellations/missed appointments are the patient's responsibility.

Chiropodist's signature: ________________________ Date: ________________

- ☐ **J. Richard Werkman**, D.Ch., B.Sc. Podiatric Medicine, Registered Chiropodist
- ☐ **Kaitlin V. Boven (nee: Werkman)**, B.Sc. (Hons) Podiatry, MSc Diabetes, Registered Chiropodist
- ☐ **Stephen Wituik**, B.A. Kin., D.Ch., Registered Chiropodist
- ☐ **Vanessa Pontet**, B.Sc. (Hon), D.Ch., Registered Chiropodist
- ☐ **Lauren Wilkins**, B.Kin., D.Ch., Registered Chiropodist
- ☐ **Matthew Collison**, BSc (Hons) MRes, MRCPod, FFPM RCPS (Glasg), Registered Chiropodist

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