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 Witiuk**, B.A. Kin., D.Ch., Registered Chiropodist
- ☐ **Vanessa Pontet**, B.Sc. (Hon), D.Ch., Registered Chiropodist
- ☐ **Lauren Wilkins**, B.Kin., D.Ch., Registered Chiropodist

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