

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)

- | | |
|--|--|
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Urinary problem | <input type="checkbox"/> Blood disease or disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach/Bowel trouble |
| <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bone disease |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer, malignancy, or tumour | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dementia or Alzheimer's | <input type="checkbox"/> 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 Chiropractor and/or support staff, also to allow photographs of treatment areas to be taken for the purposes of monitoring.
- I consent/allow the Chiropractor to contact my physician for any pertinent information required relating to my treatment or medical information.
- I consent/allow the Chiropractor 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 chiropractic, there are some very slight risks to treatment, including, but not limited to pain, swelling and infection. I do not expect the Chiropractor to be able to anticipate and explain all the risks and complications. I wish to rely on the Chiropractor'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 Chiropractors of Ontario and the law. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.

Please review our cancellation policy, including applicable fees, at werkman.ca/patient-policies. We require at least two business days' notice to cancel or reschedule an appointment. If this is not provided, a fee will be applied as outlined in the policy. All fees for cancellations/missed appointments are the patient's responsibility.

Chiropractor's signature: _____ Date: _____

- J. Richard Werkman**, D.Ch., B.Sc. Podiatric Medicine, Registered Chiropractor
- Kaitlin V. Boven (nee: Werkman)**, B.Sc. (Hons) Podiatry, MSc Diabetes, Registered Chiropractor
- Stephen Witiuk**, B.A. Kin., D.Ch., Registered Chiropractor
- Vanessa Pontet**, B.Sc. (Hon), D.Ch., Registered Chiropractor
- Lauren Wilkins**, B.Kin., D.Ch., Registered Chiropractor

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