

## Patient Information Form

Welcome! We're dedicated to providing exceptional foot care for people of all ages. Please help us get to know you better by providing the following information. Patients with serious medical emergencies should 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: \_\_\_\_\_

Date of Birth (D/M/Y): \_\_\_\_\_

Please indicate below your choice of appointment confirmation:

☐ Phone Call ☐ Email ☐ Text Message

We would also like to learn about your preferences for receiving information from us! Our clinic takes patient confidentiality seriously.

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): \_\_\_\_\_

How did you first hear about our clinic?

- ☐ Family/Friend/Colleague (Please indicate their name so we can thank them): \_\_\_\_\_
- ☐ Our Website ☐ Facebook ☐ Instagram ☐ LinkedIn
- ☐ Newspaper ☐ Health Care Professional ☐ Other (Please specify): \_\_\_\_\_

## Help us help you! Please answer the following foot questions:

Your foot problems involve:

- ☐ Right Foot ☐ Left Foot ☐ Both Feet

Why are you here today? Explain your current foot problem(s):

\_\_\_\_\_

\_\_\_\_\_

Is this problem getting:

- ☐ Worse ☐ Better ☐ Same

Have you had medical treatment for this problem? Circle one: **Y / N**

If you've had foot x-rays, when were they taken? \_\_\_\_\_

Have you been treated for: (check all that apply)

- ☐ Back pain ☐ Gout
- ☐ Warts ☐ Broken foot/leg bones
- ☐ Heel pain ☐ Flat feet
- ☐ High arch feet/pain ☐ Ankle injury
- ☐ Corns ☐ Neuroma
- ☐ Callouses ☐ Knee pain
- ☐ Bunions ☐ Ingrown Toenails
- ☐ Hammertoes ☐ Childhood foot problems

What is your current:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

On average, how much are you on your feet?

- ☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

What type of footwear do you wear most for work or leisure?

- ☐ Safety shoe ☐ Athletic ☐ Dress ☐ Sandal
- ☐ Other: \_\_\_\_\_

Do you currently use orthotics (shoe inserts)? Circle one: **Y / N**

Check any sports or activities you participate in regularly:

- ☐ Walking ☐ Running
- ☐ Aerobics/Aqua Fit ☐ Golf
- ☐ Hockey ☐ Soccer
- ☐ Racquet sports ☐ Skiing
- ☐ Other: \_\_\_\_\_

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<br>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: \_\_\_\_\_

\_\_\_\_\_

## 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 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. Note that we may use transcription-based charting during your visit to ensure accurate documentation. For more information, visit [werkman.ca/patient-policies](http://werkman.ca/patient-policies).

Please review our cancellation policy, including applicable fees, at [werkman.ca/patient-policies](http://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
- ☐ **Allen Frankel**, B. of Sc., Podiatric Surgeon

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 medication allergy: \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

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