

Dundas Chiropody Centre

Division of

Dundas Chiropractic Centre

360 Dundas Street East, Unit B4 Oakville, Ontario L6H 6Z9 (905) 257 - 5628

CASE HISTORY FORM

Name: _____ Date: _____

Address: _____

Telephone: Home _____ City/Town _____ Postal Code _____
Business: _____

Date of Birth _____ Age: _____ Weight: _____ Height: _____

Medical Doctor: _____ Phone No: _____

Occupation: _____ Where did you first hear about our office: _____

Shoe Size: _____ Email: _____

Reason for Visit: _____

Previous care by a Chiropodist? Podiatrist? If yes date of last visit: _____

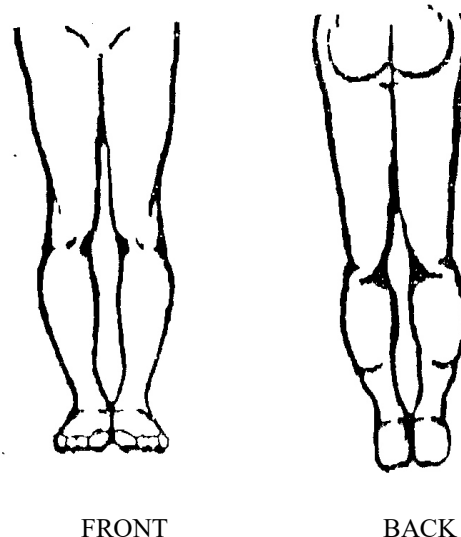
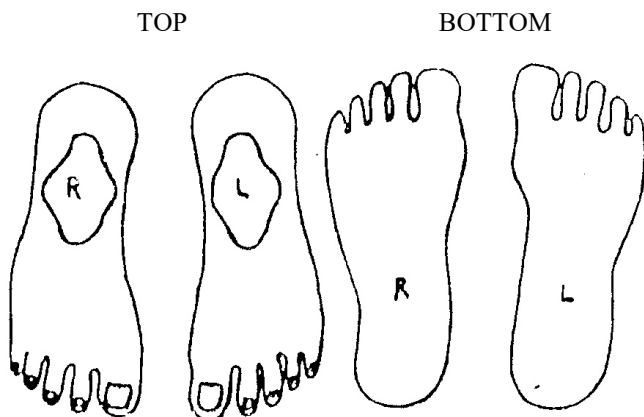
Referred to this centre through:
 Friend Newspaper Ad Newsletter
 Doctor _____ Other _____

On the diagrams provided below, mark the areas on your lower limbs and feet which you feel best represents the pain or sensation you are experiencing.

SYMBOLS

XX Burning **SS** Sharp and Stabbing **++** Dull / Aching

NN Numbness **PP** Pins and Needles



Health History

Please check those items that specifically relate to your medical history. Please answer these questions carefully, as they will be considered in establishing a suitable treatment plan for you.

Head/Ears/Eyes/Nose/Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Nose Infections |
| <input type="checkbox"/> Previous Head Injury | <input type="checkbox"/> Difficulty Hearing | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Throat Infections |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Convulsions/Seizures | |

Other ? Please Specify: _____

Cardiovascular System

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Swollen Ankles |

Other? Please Specify: _____

Respiratory

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Smoker | # of cigarettes smoked per day |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Non Smoker | <input type="checkbox"/> Have you ever smoked in the past? How Long? |

Other? Please Specify: _____

Endocrine

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Addisons Disease |
| <input type="checkbox"/> Cushings Syndrome | Other? Please Specify: _____ | |

Musculoskeletal

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Limited Joint Movement |
| Area: _____ | Area: _____ | Area: _____ | Area: _____ |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Muscle Weakness |

Have you ever fractured/
Broken any bones? Where? _____

Other? Please Specify: _____

Gastrointestinal/Genitourinary

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Kidney/Liver Disease |
| <input type="checkbox"/> Rapid Weight Loss | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Trouble Urinating | <input type="checkbox"/> Stomach Ulcers |

Other? Please Specify: _____

Childhood Illnesses

Rheumatic Fever Other? Please Specify: _____

Skin and Nails

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dry/Cracking Skin | <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> Dry/ Brittle Skin | <input type="checkbox"/> Discoloured Nails |
| <input type="checkbox"/> Moist (Sweaty) Skin | <input type="checkbox"/> Rashes/Itching | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Foot/Leg Ulcers |
| <input type="checkbox"/> Slow to Heal | <input type="checkbox"/> Warts | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Callous/Corns |

Other? Please Specify: _____

Surgery

Foot Surgery

Joint Replacement

Organ Transplant

Other? Please Specify: _____

Allergies

Have you ever had any allergies?

Other? Please Specify: _____

Psychological

Depression

Anxiety/Nervousness

Other? Please Specify: _____

Other

Have you ever been hospitalized? Reason:

If there are any other relevant medical conditions not covered on this form please outline then here:

Medications:

Please list any medications that you are currently taking below:

Have you ever experienced any side effects from local anesthetics, penicillin or other medications? If so please specify:

Please inform the Chiropodist if you ever tested HIV positive or have been diagnosed with hepatitis.

I acknowledge that all of the above information is correct. I understand that this information is confidential and will be used for no other purpose other than for the Chiropodists clinical record.

Informed Consent To Chiropodist Care

I hereby give permission for the examination and assessment of my feet, as well as give consent to perform such diagnostic procedures as may be deemed necessary.

I understand and I am informed that, as in all health care, in the practice of Chiropody there maybe some very slight risks to treatment. I wish to rely on the Chiropodist to exercise judgment during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to treatment by the Chiropodist. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Signature of Patient/Parent

Date Signed

Signature of Witness

Date Signed