

# ANCASTER FOOT CLINIC

2-352 Wilson St. E., Ancaster, ON L9G 2C2 — 905-648-9176

**Robert Nekrasas, D. Ch. — Chiropodist — Reg# 960423**

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## CONSENT TO EXAMINATION, TREATMENT AND DIAGNOSTIC PROCEDURES

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

1. I authorize chiropodist Robert Nekrasas, D. Ch., to perform examinations, treatments and diagnostics procedures within the scope of practice as outlined by the College of Chiropodist of Ontario. I also understand that authorized personnel may assist him in performing these procedures.
2. I also consent to such additional or alternative diagnostic, operative or treatment procedures as in the opinion of the medical staff performing the procedures mentioned are considered incidental to, or immediately necessary and vital to health and life of the patient.
3. I agree to the retention by Robert Nekrasas, D. Ch. for the diagnosis, research, teaching or therapy or the disposal in accordance with the accustomed practice any material that may be removed during procedures.
4. I acknowledge that there may be a charge applied by the chiropodist for the consultation, visit and treatment. I agree to pay all charges in full when they are applied \_\_\_\_\_ (initials)
5. I give permission for relevant medical information to be shared between my family physician and Ancaster Foot Clinic.
6. I certify that all the information I provide is complete and accurate \_\_\_\_\_ (initials)
8. We do not disclose any information contained in patient files without the strict written consent of the patient.

**Signature of Patient:** \_\_\_\_\_

# P A T I E N T

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (B) \_\_\_\_\_ ext \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred By: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Dr's tel.: \_\_\_\_\_

## Medical Information

Do you have Diabetes? Y \_\_\_\_\_ N \_\_\_\_\_ Do you have Neuropathy? Y \_\_\_\_\_ N \_\_\_\_\_

Are you **in good health**? .....Y \_\_\_\_\_ N \_\_\_\_\_

Have you been under a **physician's care** in the last two years? .....Y \_\_\_\_\_ N \_\_\_\_\_

Have you ever had **severe chest pains** or shortness of breath? .....Y \_\_\_\_\_ N \_\_\_\_\_

Are you subject to **prolonged bleeding**? .....Y \_\_\_\_\_ N \_\_\_\_\_

Have you ever fainted or **passed out** in a doctor's office? .....Y \_\_\_\_\_ N \_\_\_\_\_

Do you have low **back pain**? .....Y \_\_\_\_\_ N \_\_\_\_\_

Are you currently **pregnant**? .....Y \_\_\_\_\_ N \_\_\_\_\_

Do you now or have you ever **smoked**? .....Y \_\_\_\_\_ N \_\_\_\_\_

Which hand do you most often use? .....R \_\_\_\_\_ L \_\_\_\_\_ B \_\_\_\_\_

Have you had any **major operations**? \_\_\_\_\_

Have you ever been treated for any of the following? .....

Heart	Kidney	Asthma	Phlebitis	Epilepsy	Anemia
Liver	Cancer	Ulcers	Gout	Arthritis	Clotting
Parkinson's	Scarlet Fever	Rheum Fever	High BP	Low BP	Healing Problems
AIDS	Thyroid	Psoriasis	Blood borne infections	TB	

**Podiatric Information**

Do you ever have foot or leg **cramps**? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do you ever get **numbness** in your feet or toes? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do you ever get **tingling** in your feet or toes? .....Y\_\_\_\_\_ N\_\_\_\_\_

Have you ever had any **itching** in your feet? .....Y\_\_\_\_\_ N\_\_\_\_\_

Have you ever had any major foot or **leg injuries**? ..... Y\_\_\_\_\_ N\_\_\_\_\_

Have you ever had any foot or **leg surgery**? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do or did **your parents** ever have any foot problems? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do your feet **perspire** excessively? .....Y\_\_\_\_\_ N\_\_\_\_\_

Are your feet excessively **dry**? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do your feet have a strong **odour**? .....Y\_\_\_\_\_ N\_\_\_\_\_

Do you treat your own feet or cut your own **callouses**? .....Y\_\_\_\_\_ N\_\_\_\_\_

Have you ever had your feet treated **before**? .....Y\_\_\_\_\_ N\_\_\_\_\_

By a Podiatrist\_\_\_\_\_ Chiropracist\_\_\_\_\_ Orthopedic Surgeon\_\_\_\_\_ Pedicurist\_\_\_\_\_ Other\_\_\_\_\_

Do you generally find your feet to be.....Hot\_\_\_\_\_ Cold\_\_\_\_\_ Normal \_\_\_\_\_

When walking, do you.....Toe In\_\_\_\_\_ Toe Out\_\_\_\_\_ Walk Straight\_\_\_\_\_

**History**

What is **your specific** foot problem? \_\_\_\_\_

**How long** have you had this problem? \_\_\_\_\_

What have you **done** about it? \_\_\_\_\_

Has this condition been seen by your **family doctor**? \_\_\_\_\_

Or **other clinician**? \_\_\_\_\_

Result of this care? \_\_\_\_\_

Does this problem affect your walking or **normal functioning**? \_\_\_\_\_

How much? \_\_\_\_\_

**What type of pain is it?**

- Sharp  Bruised  Aching
- Dull  Throbbing  Hot
- Sore  Stabbing  Tender
- Numb  Burning  Other

**Onset**

- Sudden  Gradual
- Constant  Intermittent

**When does pain occur?**

- Upon Walking  On Standing
- During Walking  Lying in Bed
- After Walking  Spontaneously
- During work  Fancier Shoes
- After Work  Always Present
- On Contact  Comes & Goes

**Duration**

- < than 1 week  >6 months
- 1 to 2 weeks  >1 year
- 1 Month  >3 years
- 1 to 3 months  >5 years
- >3 months  Always

**Other Complaints**

- Legs \_\_\_\_\_
- Knees \_\_\_\_\_
- Hips \_\_\_\_\_
- Back \_\_\_\_\_
- Usage \_\_\_\_\_

**Sports and Activities**

- Tennis  Walking
- Squash  Gardening
- Racquetball  Dancing
- Badminton  Skating
- Cycling  Skiing
- Exercises  Aerobics
- Swimming  Running
- Golf  Other \_\_\_\_\_

**Allergies**

- Aspirin \_\_\_\_\_
- Cortisone \_\_\_\_\_
- Sulphas \_\_\_\_\_
- Codeine \_\_\_\_\_
- Novocaine \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Erythro. \_\_\_\_\_
- Tape \_\_\_\_\_
- Other \_\_\_\_\_

**Medications: Please list**

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