

CONFIDENTIAL PATIENT INFORMATION

DATE:

FIRST NAME:

MIDDLE NAME:

LAST NAME:

ADDRESS:

APT #:

CITY:

PROV:

POSTAL CODE:

DATE OF BIRTH (D/M/Y):

AGE:

MALE / FEMALE / _____

OF CHILDREN:

IF MINOR, NAME & CONTACT INFO OF PARENT/GUARDIAN:

**NAME:
NAME:**

**MOBILE:
MOBILE:**

**E-MAIL:
E-MAIL:**

OCCUPATION:

COMPANY NAME:

IF STUDENT, NAME OF SCHOOL:

GRADE/YEAR:

MARITAL STATUS: *M / S / SEP / DIV / Wid / Eng / Com-Law*

VISA / MC #:

EXP:

METHOD OF CONTACT:

PLEASE DISCUSS FREQUENCY & METHOD OF APPOINTMENT REMINDERS – Default: 5d, 3d, 2hrs

HOME:

BEST METHODS OF CONTACT: Home Cell Work e-Mail

CELL:

WORK:

NAME OF FAMILY DR. / PHONE #:

E-MAIL:

REFERRED BY: LOCATION SIGN INTERNET FRIEND FAMILY DOCTOR OTHER:

IF BY INTERNET: Search Engine Used:

Word Used:

IF BY FRIEND/FAMILY, NAME:

IF BY DOCTOR, NAME / ADDRESS:

REASON FOR TODAY'S VISIT:

- BUNIONS CORNS DIABETIC CARE NAIL CARE PAIN SKIN PROBLEM WARTS
 ORTHOTICS (NEW / INQUIRY ONLY) PRESCRIPTION (ORTHOTICS / SHOES)
 OTHER:

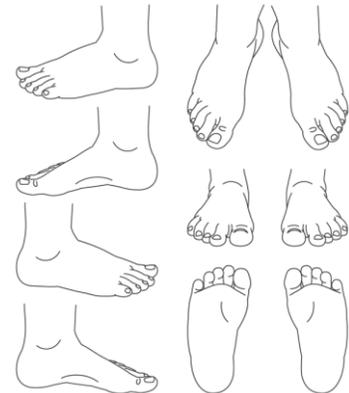
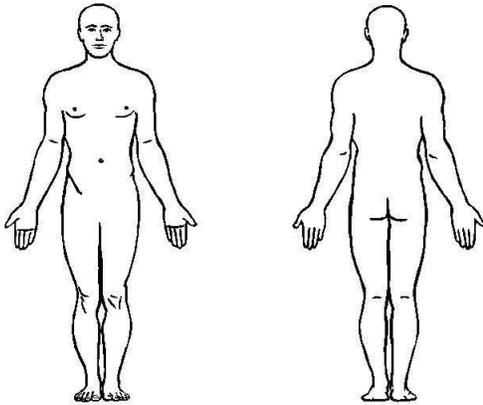
HOW LONG HAVE YOU HAD THIS CONDITION:

HAVE YOU HAD PREVIOUS CHIROPODY/PODIATRY CARE?

Y / N

IF YES, NAME:

HEALTH QUESTIONNAIRE - *Please MARK and DESCRIBE where you are experiencing problems*



MEASUREMENT / FOOTWEAR & ORTHOTICS: OUTDOORS / INDOORS

Weight	Variety:	Athletic:	Men dress:	Ladies dress:	Indoor footwear:
	<input type="checkbox"/> Blundstones	<input type="checkbox"/> stability	<input type="checkbox"/> Oxfords/Derby	<input type="checkbox"/> flats	<input type="checkbox"/> barefoot
	<input type="checkbox"/> Birkenstocks	<input type="checkbox"/> lightweight	<input type="checkbox"/> Loafer	<input type="checkbox"/> heels: 1" / 2"	<input type="checkbox"/> socks
	<input type="checkbox"/> deck shoes	<input type="checkbox"/> running	<input type="checkbox"/> Dress boots	<input type="checkbox"/> heels: 3' / 4'+	<input type="checkbox"/> Birkenstocks
	<input type="checkbox"/> Converse	<input type="checkbox"/> walking	<input type="checkbox"/> Chelsea boots	<input type="checkbox"/> converse-like	<input type="checkbox"/> Mephisto
Height	<input type="checkbox"/> Vans & like	<input type="checkbox"/> tennis	<input type="checkbox"/> Other:	<input type="checkbox"/> Oxfords	<input type="checkbox"/> Finn Comfort
	<input type="checkbox"/> Toms & like	<input type="checkbox"/> hiking		<input type="checkbox"/> other:	<input type="checkbox"/> Crocs/UGGS
	<input type="checkbox"/> safety boots	<input type="checkbox"/> other:			<input type="checkbox"/> slippers
	<input type="checkbox"/> orthopedic				<input type="checkbox"/> shoes+orthotics
Shoe size	<input type="checkbox"/> diabetic				<input type="checkbox"/> shoes only
	<input type="checkbox"/> other:	Orthotics:			<input type="checkbox"/> flip flops
		<input type="checkbox"/> worn 100%	<input type="checkbox"/> worn occasionally	<input type="checkbox"/> worn in the past	<input type="checkbox"/> other:
		<input type="checkbox"/> not worn	<input type="checkbox"/> if not worn, reason:		

HEALTH QUESTIONNAIRE - Please check off conditions/symptoms which you may have now or have had in the past.

GENERAL	DIABETES	FOOT ISSUES	JOINT-MUSCLE PAIN
<input type="checkbox"/> Allergies, list:	<input type="checkbox"/> Onset:	<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Ankle pain R / L
<input type="checkbox"/> Asthma	<input type="checkbox"/> Controlled by:	<input type="checkbox"/> Bunions	<input type="checkbox"/> Lower leg pain R / L
<input type="checkbox"/> Arthritis: OA / RA / Psor	<input type="checkbox"/> Diet	<input type="checkbox"/> Who in family:	<input type="checkbox"/> Knee pain R / L
<input type="checkbox"/> Blood pressure: low/high (N:<130/80)	<input type="checkbox"/> Medications	<input type="checkbox"/> Callus	<input type="checkbox"/> Hip pain R / L
<input type="checkbox"/> Cancer, describe:	<input type="checkbox"/> Insulin	<input type="checkbox"/> Corns	<input type="checkbox"/> Back pain
<input type="checkbox"/> Cholesterol problem (N: <2.0mmol/L)	<input type="checkbox"/> History of ulcers	<input type="checkbox"/> Ingrown nails	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Depression	<input type="checkbox"/> Y / N	<input type="checkbox"/> Fungal nails	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Location:	<input type="checkbox"/> Flat arches	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Hearing problem	<input type="checkbox"/> Orthotics worn?	<input type="checkbox"/> High arches	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> HIV+ / AIDS	<input type="checkbox"/> Y / N / sometimes	<input type="checkbox"/> In-toeing	<input type="checkbox"/> Previous injuries:
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Supportive shoes?	<input type="checkbox"/> Out-toeing	<input type="checkbox"/> car accident / MVA
<input type="checkbox"/> Reynaud's' syndrome	<input type="checkbox"/> Y / N / sometimes	<input type="checkbox"/> Warts	<input type="checkbox"/> ankle sprains
<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Family history	<input type="checkbox"/> Heel pain R / L	<input type="checkbox"/> fractures
<input type="checkbox"/> Thyroid, describe:	<input type="checkbox"/> Y / N	<input type="checkbox"/> Big toe pain R / L	<input type="checkbox"/> slips
<input type="checkbox"/> Veins: varicose / spider	<input type="checkbox"/> Whom:	<input type="checkbox"/> Arch pain: R / L	<input type="checkbox"/> falls
<input type="checkbox"/> Vision, describe:	<input type="checkbox"/> Blood sugar level: (N: 4.0-7.0mmol/L)	<input type="checkbox"/> Ball of foot pain: R / L	<input type="checkbox"/> other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Your latest reading:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

LIFESTYLE QUESTIONNAIRE

SPORTS / EXERCISE	SMOKING	DRINKING	SURGICAL HISTORY
<input type="checkbox"/> Do you exercise? Y / N	<input type="checkbox"/> Do you smoke? Y / N / Never / Socially	<input type="checkbox"/> Do you drink? Y / N / Socially	<input type="checkbox"/> Hip replac't: R / L
<input type="checkbox"/> Days / week:	<input type="checkbox"/> Quit date:		<input type="checkbox"/> Knee replac't: R / L
<input type="checkbox"/> Days / month:	<input type="checkbox"/> Pack / day:		<input type="checkbox"/> Bunionectomy: R / L
<input type="checkbox"/> Type of exercise:	<input type="checkbox"/> Number of years:		<input type="checkbox"/> Other:

MEDICATIONS PRESENTLY TAKEN:

INFORMED CONSENT TO CHIROPODY TREATMENT / VISIT

I hereby request and consent to Chiropractic treatment on me by the Chiropractor and/or anyone in the clinic authorized by the Chiropractor including, but not limited to:

- various modes of physical therapy (low volt/interferential, therapeutic ultrasound, laser, shockwave, ART, FMT, Acupuncture, etc.),
- local anaesthesia,
- conservative or surgical nail treatments for ingrown or fungal conditions,
- custom orthotics (casting with 3D laser scan or foam box),
- various wart treatments, etc.

I understand that I will have an opportunity to discuss and understand the nature and purpose of any procedures with the Chiropractor and/or with other clinic personnel before any treatment is performed.

I understand that results are not guaranteed.

I understand that there are some associated risks to treatments, including, but not limited to pain, swelling and infection.

The Chiropractor cannot be held responsible for any unforeseen risks or complications that may result.

I wish to rely on the Chiropractor to exercise judgement during the course of the procedure which the Chiropractor feels at the time, based upon the facts then known, is in my best interest.

I HAVE READ THE ABOVE CONSENT.

I INTEND FOR THIS CONSENT FORM TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I MAY SEEK TREATMENT.

DATE:

SIGNATURE OF PATIENT/PARENT/GUARDIAN:

ACADEMY FOOT & ORTHOTIC CLINICS

www.academyclinics.com
academyclinics@gmail.com

752 Broadview Ave.
Toronto, ON M4K 2P1

CHIROPODY FEE SCHEDULE

Initial Visit	180
Treatment	100
Biomechanical Exam	120
Custom Orthotics	500
Fungal Nail Laser Treatment	320
Laser Wart Removal	150
Shockwave Therapy	180
Toenail Surgery	700-900
Local Anesthesia	100
Therapy	
Physical Therapy	80
A.R.T – Active Release Therapy	80
F.M.T – Foot Mobilization Technique	80
Swift Wart Treatment	300

This is to inform our patients that no part of Chiropody services is covered by OHIP, although these services are covered by most Extended Health Insurance Plans, Department of Veteran Affairs (DVA) and Worker's Safety Insurance Board (WSIB).

Please note:

- **The patient is responsible for any deductibles and co-insurance fees**
- **Payment is due when services are rendered**

I understand and agree to the aforementioned terms and I agree to pay for services rendered.

LATE/CANCELLATION POLICY

Please read and initial at the bottom

Our Chiropodists are highly sought after and can only see a number of patients per day. As your appointment is reserved specifically for you, please provide **24** hours notice to cancel or reschedule.

Out of respect for the time of our staff and patients, we will be mailing out an invoice to any client who does not show up or cancels with less than **24** hours notice.

If you arrive late for your appointment, we will try to accommodate you, however, your treatment time may be shortened to maintain clinic schedule. Please expect to be billed for the full cost of the original booking.

Initial _____

Signature

Date

ACADEMY FOOT & ORTHOTIC CLINICS

INSURANCE INFORMATION

Please fill out the following with your insurance information so the clinic can verify your coverage.

• **Does your spouse have extended Health Care Insurance?**

YES, complete below:

SPOUSE'S INSURANCE

NAME: _____

NAME: _____

D.O.B. d/m/y: _____
Date of birth

D.O.B. d/m/y: _____
Date of birth

INSURACY COMPANY: _____

INSURACY COMPANY: _____

POLICY GROUP # _____

POLICY GROUP # _____

CERTIFICATE ID # _____

CERTIFICATE ID # _____

EMPLOYER: _____

EMPLOYER: _____

FOR OFFICE USE ONLY

COVERAGE FOR:	% Covered	\$ Max	Per year	Per Visit	Deductible
D.Ch. Visits					
Orthotics					
Orthopedic Shoes <input type="checkbox"/> OTC <input type="checkbox"/> Custom Made				Notes:	
Compression Socks				Gradient: <input type="checkbox"/> 15-20mmHg <input type="checkbox"/> 20-30mmHg <input type="checkbox"/> >40mmHg	Referred By: <input type="checkbox"/> MD <input type="checkbox"/> D.Ch. <input type="checkbox"/> Other

Orthotic and Shoe Submission Requirements:

- | | |
|-------------------------------------------------------------------------|---------------------------------------------|
| Referred By: <input type="checkbox"/> MD <input type="checkbox"/> D.Ch. | <input type="checkbox"/> Paid in full |
| <input type="checkbox"/> P/up date | <input type="checkbox"/> Biomechanical Exam |
| <input type="checkbox"/> Lab invoice | <input type="checkbox"/> Make/Model of shoe |
| <input type="checkbox"/> Assignment of benefits | |

Date Called:	Rep's Name

Insurance Billing Address: _____
