



Welcome to: KYLE FOOT & ORTHOTICS CLINIC
 746 Baseline Rd., E., Suit 203,
 London, ON N6C 5Z2
 Tracy Kyle, D.Ch., Chiroprapist – Foot Specialist

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ SEX: M F
 MAILING ADDRESS: _____ CITY: _____ POSTAL CODE: _____
 HOME PHONE: () _____ AGE: _____ DATE OF BIRTH: ____/____/____
Month Day Year
 E-MAIL: _____
 EMPLOYER: _____ PHONE: () _____ EXT _____
 OCCUPATION: _____ MAY WE CALL YOU AT WORK? Y N HOURS: _____
 (PARENT/GUARDIAN NAMES (if child is under 18): MOTHER: _____ FATHER: _____)

INSURANCE INFORMATION :

PRIMARY INSURANCE COMPANY: _____ PHONE #: () _____
 INSURED'S NAME: _____ ID#: _____ GROUP #: _____

IN CASE OF EMERGENCY:

WHO SHOULD BE NOTIFIED? _____ RELATIONSHIP: _____ PHONE () _____

HOW DID YOU FIND OUT ABOUT OUR CLINIC?

DR. REFERRAL: Who? _____ FRIEND: Who? _____ RELATIVE: Who? _____
 YELLOW PAGES NEWSPAPER: Which? _____ OTHER: _____

PLEASE READ & SIGN BELOW: I understand that I am financially responsible for all charges, whether covered by my health insurance plan or not. I authorize the chiroprapist to release all information necessary to secure the benefit of payments. I understand that fees for service are payable at the time of service, and that chiroprody services in the province of Ontario are not covered under my provincial health plan (OHIP). Insurance reimbursement is my responsibility.

Certain services will incur charges over and above the base office visit fee.

I HEREBY GIVE AUTHORIZATION FOR EXAMINATION & TREATMENT: _____
 SIGNATURE REQUIRED DATE

☆☆ **PLEASE COMPLETE OPPOSITE SIDE** ↗

PATIENT MEDICAL HISTORY

Your foot problems involve:

Both feet Left foot only Right foot only Other

Describe your current foot problem(s): _____

How long has this been a problem?: _____

When is this problem most bothersome? _____

Is this problem getting: worse / better / same? (Circle one)

Have you had medical treatment for this problem? Y N

Previous foot xray s? Y N If yes, Date: _____

Describe all attempted treatments or home remedies: _____

What is your current:

Height: _____ Weight: _____ Shoe size: _____

Has your weight changed in the last year? Y N

If yes, how much? _____ Increase Decrease

How much are you on your feet at work: (Circle one)

20 % 40 % 60 % 80 % 100 %

What type of footwear do you wear to work?:

Safety shoe boot Athletic Dress Sandal Other

Check any sports or activities you participate in regularly:

Walking Running Aerobics / Aqua Fit Golf

Hockey Soccer Racquet sports Skiing

Others: _____

Please list your current prescription medications:

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

7 _____ 8 _____

Have you ever been treated for:

(check all that apply)

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Broken foot/leg bones | <input type="checkbox"/> Heel pain | <input type="checkbox"/> Corns |
| <input type="checkbox"/> High arch feet | <input type="checkbox"/> Flat feet | <input type="checkbox"/> Callouses |
| <input type="checkbox"/> Ankle Injiry | <input type="checkbox"/> Bunions | <input type="checkbox"/> Neuroma |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Arch pain |
| <input type="checkbox"/> Ingrown Nails | <input type="checkbox"/> Childhood Foot Problems | |

Do you have, or have you ever been treated for:

(check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes: Type 1 | <input type="checkbox"/> Type 2 | <input type="checkbox"/> How Long _____ |
| <input type="checkbox"/> Heart trouble | <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 | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stomach/bowel trouble | <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 | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Back Problems |

Do you have allergies to:

- Penicillin, Sulfa, Erythromycin? Y N Don't Know
- Narcotics? (codeine, demerol, morphine) Y N Don't Know
- Local anesthetics? (Xylocaine, Novocaine) Y N Don't Know
- Pain remedies? (Tylenol, aspirin, etc.) Y N Don't Know
- Adhesive tapes/ bandaids? Y N Don't Know
- Latex? Y N Don't know
- Environmental allergens?(dust,pollen) Y N Don't know
- Other drug, medication, treatment? Y N Don't Know
- ↳ Indicate allergen(s): _____

Are you slow to heal after cuts? Y N

Do you bruise easily? Y N

Do your feet hurt in bed at night? Y N

Any pain in calves / buttocks when walking? Y N

↳ Is this pain relieved by rest? Y N

Are you currently pregnant or nursing? Y N

Do you smoke? Y N If you q it, how long ag ? _____

PATIENT PHYSICIANS

• Family physician: _____ Date last seen: _____ Phone: () _____ City: _____

Did your family Dr. refer you to us? Y N Has your Dr. treated your foot condition? Y N How: _____

• Other Doctor: Name: _____ Type of Dr.: _____ Did this doctor refer you to us? Y N

• Other Doctor: Name: _____ Type of Dr.: _____ Did this doctor refer you to us? Y N

☆**IMPORTANT:** May we send a report of your foot exam to your Family Physician and/or your referring Doctor? Y N

FAMILY HISTORY:

Has any blood relative had: Diabetes? Y N Who? _____ What type? _____

Foot Problems? Y N Who? _____ Type? _____ Arthritis? Y N

☺ **THANKOU - PLEASE RETURN THIS FORM TO THE RECEPTIONIST** ☺