Welcome To: Kyle Foot & Orthotics Clinic
(Medcen Building)
339 Wellington Rd. South, Unit #135
London, Ontario N6C 5Z9
Tracy Kyle, D.Ch., Chiropodist- 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:_____ Employer Phone: ( )_____EXT_____

Occupation:_____ May we call you at work? ☐ Yes ☐ No

Parent / Guardian Names (If child is under 18): Mother: _____ Father: _____

Insurance Information:

Primary Insurance Company: _____ Phone: ( )_____

Insured Members Name:_____ ID#_____ Plan#_____

In Case of Emergency:

Who should be notified? _____ Relationship: _____ Phone: ( )_____

How did you find out about our clinic? _____

PLEASE READ AND SIGN BELOW: I understand that **I am financially responsible for all charges including no show fees stated in the no show policy,** whether covered by my health insurance plan or not. Orthotics are custom made and are not returnable. I authorize the Chiropodist 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 Chiropody services in the province of Ontario are not covered under my provincial health plan (OHIP). Insurance reimbursement is my responsibility. I have received the information that explains how your office will use my personal information. I know your office has a Privacy Code, and that I can see the Code at any time. I agree that Kyle Foot and Orthotic Clinic can collect, use, and disclose personal information about me as set out in their office's privacy policies.

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

Date:_____ Print Name:_____ Signature:_____

Patient Medical History:

Where is the pain in your feet?

- ☐ Both Feet
- ☐ Left Foot Only
- ☐ Right Foot Only
- ☐ Other

Left Foot **Right Foot**

Describe your current foot problems:

_____

_____

How long has this been a problem for you?

_____

When is this problem most bothersome?

_____

_____

Describe all attempted treatment for this problem?

_____

_____

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

Have you had medical treatment for this problem?

_____

_____

Have you had X-Rays done for this problem?

_____

How much are you on your feet at work?

20% 40% 60% 80%

What type of footwear do you wear to work?

- ☐ Safety Boots/ Shoes
- ☐ Sandals
- ☐ Other
- ☐ Dress
- ☐ Athletic

Check any sports of activities you participate in regularly:

- ☐ Walking
- ☐ Golf
- ☐ Soccer
- ☐ Running
- ☐ Hockey
- ☐ Racquet Sports
- ☐ Aerobics / Aqua Fit
- ☐ Skiing
- ☐ Other

Please list your current medications:

_____

_____

Have you been treated for: (Check all that apply?)

- ☐ Back pain
- ☐ Broken Foot/ Leg
- ☐ High Arch Feet
- ☐ Ankle Injury
- ☐ Hammertoes
- ☐ Ingrown Nail
- ☐ Gout
- ☐ Callouses
- ☐ Arch Pain
- ☐ Heel Pain
- ☐ Flat Feet
- ☐ Bunions
- ☐ Knee Pain
- ☐ Childhood Foot Problems
- ☐ Warts
- ☐ Corns
- ☐ Neuroma

Do you have any of have ever been treated for?

Diabetes ☐ Type 1 ☐ Type 2 How Long? _____

- ☐ Heart Troubles
- ☐ Thyroid Problem
- ☐ Urinary Problem
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Shortness of breath
- ☐ Back Problems
- ☐ Skin Disorder
- ☐ Liver Disorder
- ☐ Stomach/Bowel
- ☐ Stroke
- ☐ Bone Disease
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Depression
- ☐ Anxiety
- ☐ Cholesterol
- ☐ Epilepsy

Do you have allergies to:

Local Anesthetics? (Xylocaine, Novocain) ☐ Yes ☐ No

Adhesive Tapes / Band-Aids? ☐ Yes ☐ No

Latex? ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If you quit, how long ago?

_____

What is your current:

Height: _____ Weight: _____ Shoe Size: _____

Has your weight changed in the last year? ☐ Yes ☐ No

If Yes, How much? _____ Increase / Decease

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:_____

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