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

Patent / 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?

☐ Dr Referral:_____ ☐ Relative:_____ ☐ Other:_____

☐ Yellow Pages: ☐ Friend: _____

PLEASE READ AND SIGN BELOW: I understand that **I am financially responsible for all charges,** whether covered by my health insurance plan or not. 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 un 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 and treatment:_____ Date: _____

Patient Medical History:

Your foot problem involves:

☐ 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?

☐ Yes ☐ No

Previous x-rays? ☐ Yes ☐ No

Describe all attempted treatments or home remedies:

_____

_____

What is your current:

Height: _____ Weight: _____ Shoe Size_____

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

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 ☐ Skiing

☐ Golf ☐ Hockey ☐ Soccer ☐ Racquet Sports

☐ Other_____

Please list your current prescription medication:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

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

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

Do you have or have you 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
☐ Skin Disorder
☐ Liver Disorder
☐ Stomach/Bowel Troubles
☐ Stroke
☐ Bone Disease
☐ Cancer
☐ Tuberculosis
☐ Hepatitis
☐ HIV/AIDS
☐ Depression
☐ Anxiety
☐ Cholesterol
☐ Epilepsy
☐ Back Problems

Do you have allergies to:

Penicillin, Sulfa, Erythromycin	☐ Y	☐ N	☐ Unknown
Narcotics? (Codeine, Demerol, Morphine)	☐ Y	☐ N	☐ Unknown
Local Anesthetics? (Xylocaine, Novocain)	☐ Y	☐ N	☐ Unknown
Pain Remedies (Tylenol, Aspirin, etc.)	☐ Y	☐ N	☐ Unknown
Adhesive Tapes/ Band-Aids?	☐ Y	☐ N	☐ Unknown
Latex?	☐ Y	☐ N	☐ Unknown
Environmental Allergens? (Dust, Pollen)	☐ Y	☐ N	☐ Unknown
Other Drug, Medications, or Treatments	☐ Y	☐ N	☐ Unknown

- Indicate Allergen(s):_____

Are you slow to heal after cuts?	☐ Y	☐ N	☐ Unknown
Do you bruise easily?	☐ Y	☐ N	☐ Unknown
Do your feet hurt in bed at night?	☐ Y	☐ N	☐ Unknown
Any pain in calves / buttocks when walking?	☐ Y	☐ N	☐ Unknown
-Is this pain relieved by rest?	☐ Y	☐ N	☐ Unknown

Are you currently pregnant or nursing? ☐ Y ☐ N

Do you smoke? ☐ Y ☐ N -If you quit, how long ago? _____

Patient Physicians:

Family Physician: _____ Date Last Seen: _____ Phone: ( ) _____ City: _____

Did your family Dr. refer you to us? ☐ Y ☐ N Have your Dr. Treated your foot condition? ☐ Y ☐ N How: _____

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? _____ What type? _____ Arthritis? ☐ Y ☐ N

THANK YOU- PLEASE RETURN THIS FORM TO THE RECEPTIONIST