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:_____________________________ Gender: __________________

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. **Failure to give two business days' notice of any cancellation, failure to show up for your appointment and any late arrivals will result in a full appointment fee that will need to be paid prior to rebooking**. 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

**Right Foot** **Left 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 / Decrease

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