ACHILLES
FOOT CLINIC

WELCOME TO OUR OFFICE

Name: _____ Alberta Health: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Hm Ph#: _____ Cell Ph # _____

Work Ph #: _____ Occupation: _____

Email Address: _____

Age: _____ Birth date (MON/DD/YYYY): _____

Emergency Contact: _____ Ph#: _____

Your Physician's Name: _____ Ph#: _____

How did you hear about the clinic? Please circle which one applies: Radio 97.7, Herald, Internet, Sign, Dr. Ref, Patient Ref, Yellow Pages or Other: _____

Former Podiatrist: _____ Approximate date of last visit: _____

Insurance Company: Alberta Blue Cross, Greenshield, Great West Life (Canada life). Please circle one.
Group number, policy number :

_____

What is your present foot problem?

_____

PLEASE ANSWER EACH QUESTION

1. Are you in good health? Yes__No__

2. Are you or have been under the care of a Physician during the past two years for any ongoing issues?
   If so what for? _____ Yes__No__

3. Are you subjected to prolonged bleeding after a cut? Yes__No__

4. Are you a slower healer or do you scar easily? Yes__No__

5. Do you have any drug and or food allergies (i.e. Penicillin, Sulfa, Novocaine) Yes__No__
   If yes, what? _____

6. Have you ever had cortisone therapy? Yes__No__

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7. Have you had any injuries or surgery to your legs or feet? Yes__No__

8. Have you ever experienced any unfavorable reaction from any previous Podiatric treatment? Yes__No__

9. What medications are you presently taking?_____

_____

10. What is your: Ht _____ cm/in; Wt _____ kg/lbs; Average Shoe Size _____

11. Have you ever been treated for any of the following?

Diabetes Mellitus	Yes__No__	Asthma, Hay Fever	Yes__No__
Heart Problems	Yes__No__	Kidney Ailments	Yes__No__
High Blood Pressure	Yes__No__	Liver Ailments	Yes__No__
Circulation Problems	Yes__No__	Arthritis	Yes__No__
Rheumatic Fever	Yes__No__	Low Back Pain	Yes__No__
Anemia, Blood Disorder	Yes__No__	Skin Problems	Yes__No__
Lung Problems	Yes__No__	Nervous System Disorders	Yes__No__
Epilepsy	Yes__No__	Hepatitis	Yes__No__

12. Is there any other information or history about your health which should be known?

_____

_____

_____

_____

I give my permission to administer treatment, as discussed and agreed upon with the physician. In addition, perform such procedures as may be necessary in the diagnosis and/or treatment of my foot condition.

Patient/Guardian Signature:_____Date:_____