# DURHAM FAMILY FOOT CARE CLINIC & WELLNESS CENTRE

**ROBERT CHELIN, D.P.M. (Podiatrist)**
**STEPHEN PARKER, D. Ch. (Chiropodist)**

**FOR PATIENT PROTECTION, ALL INSTRUMENTS ARE COMPLETELY STERILIZED BEFORE EACH TREATMENT ACCORDING TO REGULATIONS.**

We are pleased you have confided in us for your foot care. The staff wishes to welcome you to our office. We take pride in our professional capabilities and will attempt to accommodate you in every way possible. We accept new patients without Doctor referral. Adult foot problems begin in childhood. Please have your children's and grandchildren's feet examined!

Please answer the following questions **fully** to help us become better acquainted. If you need assistance do not hesitate to ask the receptionist.

Email: _____

Name _____ Date _____

Parent or Guardian's name if patient is under age 18 _____

Address _____ Apt. # _____

City/Town _____ Postal Code ☐☐☐ - ☐☐☐

Phone Number (Home) ( ) _____ (Mobile) ( ) _____ Ext. _____

Health Card Number ☐☐☐☐☐☐☐☐☐☐ ☐☐ Expiry Date _____

Version Code

DAY    MONTH    YEAR

Date of Birth ☐☐☐  ☐☐☐  ☐☐☐

Shoe Size _____ Weight _____ Age _____

Occupation _____

Employer _____

Are you or your spouse covered under any additional type of medical insurance that covers prescriptions, eyeglasses or dental eg: Great West Life, Blue Cross, Aetna, etc.

☐ Yes    ☐ No

How did you hear about our office, or who referred you? _____

Name of person who referred you _____

Are you allergic to medications or material?    ☐ Yes    ☐ No

If yes specify _____

Is there a personal or family history of diabetes?    ☐ No    ☐ Self    ☐ Mother    ☐ Father

If self:    ☐ Pills    ☐ Insulin Injections

**CONTINUED ON OTHER SIDE...**

# DURHAM FAMILY FOOT CARE CLINIC & WELLNESS CENTRE

**ROBERT CHELIN, D.P.M. (Podiatrist)**
**STEPHEN PARKER, D. Ch. (Chiropodist)**

We are pleased you have confided in us for your foot care. The staff wishes to welcome you to our office. We take pride in our professional capabilities and will attempt to accommodate you in every way possible. We accept new patients without Doctor referral. Adult foot problems begin in childhood. Please have your children's and grandchildren's feet examined!

Please answer the following questions **fully** to help us become better acquainted. If you need assistance do not hesitate to ask the receptionist.

Email: _____

Name _____ Date _____

Parent or Guardian's name if patient is under age 18 _____

Address _____ Apt. # _____

City/Town _____ Postal Code ☐☐☐ - ☐☐☐

Phone Number (Home) ( ___ ) _____ (Mobile) ( ___ ) _____ Ext. _____

Health Card Number ☐☐☐☐☐☐☐☐☐☐☐☐   ☐☐   Expiry Date _____

Version Code

|  | DAY | MONTH | YEAR |
|---|---|---|---|
| Date of Birth | ☐☐ | ☐☐ | ☐☐☐ |

Shoe Size _____ Weight _____ Age _____

Occupation _____

Employer _____

Are you or your spouse covered under any additional type of medical insurance that covers prescriptions, eyeglasses or dental eg: Great West Life, Blue Cross, Aetna, etc.

☐ Yes   ☐ No

How did you hear about our office, or who referred you? _____

Name of person who referred you _____

Are you allergic to medications or material?   ☐ Yes   ☐ No

If yes specify _____

Is there a personal or family history of diabetes?   ☐ No   ☐ Self   ☐ Mother   ☐ Father

If self:   ☐ Pills   ☐ Insulin Injections

**CONTINUED ON OTHER SIDE...**

Are you pregnant?　　☐ Yes　　☐ No　　☐ Maybe

**\*If yes or maybe please inform receptionist!**

Do you wear high heels?　　☐ Occasionally　　☐ For Work　　☐ Daily　　☐ Never

At present, do you take any medications regularly, including birth control?

☐ Yes　　☐ No　　(Please list) _____

_____

Have you ever tested HIV POSITIVE?　　☐ Yes　　☐ No　　☐ Have not been tested

Do you have any diseased or medical conditions?　　☐ Yes　　☐ No

What are they _____

Are you subject to prolonged bleeding:　☐ Yes　☐ No　/　Are you taking blood thinners?　☐ Yes　☐ No

Do you have problems healing:　☐ Yes　☐ No　/　Are you prone to infection?　☐ Yes　☐ No

Have you been treated or had surgery for any serious medical problems, ie. Heart, Kidney, etc?

(Please list) _____

Have you ever fainted in a doctor's office:　☐ Yes　☐ No　/　Or when giving blood　☐ Yes　☐ No

Name of family doctor _____　Last visit _____

Address or street _____　Phone ( 　　　 ) _____

Have you ever had your feet examined?　☐ Yes　☐ No　By whom: _____

Name of former Podiatrist/Chiropodist _____

Have you ever worn orthotics (shoe inserts)?　　Yes　　No　　Who made them? _____

What is your foot problem? _____

_____

_____ as opposed to an M.D. (Medical Doctor) consequently there is a fee for examination, x-rays (if necessary) and/or treatment. You are responsible for fees the day of your visit!

_____　　　　_____
Date　　　　　　　　　　　　　　　　　　　Signature

Occasionally, we must change or confirm a future appointment. Who can we call if we cannot reach you?

(neighbour, relative, friend, etc.)　Phone Number ( 　　　 ) _____

Name _____　Relationship _____