5521 206th Street – Langley, BC V3A 2C6

LANGLEY FOOT CLINIC

Tel: 778-278-5550 Fax: 1-866-591-9539

Welcome to Our Practice

Our goal is to provide patients with the best quality foot care possible
Please take a few minutes to fill out the following information

Patient information:

First Name_____ Last Name _____

Date of Birth (MM/DD/YY) _____Age _____ ☐ Male ☐ Female

Address_____ City_____ Postal Code_____

Phone: (Home) _____Cell _____(Business)_____

Email address_____

May we contact you by email to confirm your appointments or provide additional information: ☐ Yes / ☐ No

Occupation_____ Employer_____

Emergency Contact_____ Relationship_____

Phone: _____

Parent/Guardian Names (if child is under 18): Mother_____ Father _____

How did you first hear about our office?

Friend/family/colleague _____

(Please indicate referrer's name so we may thank them)

☐ Internet ☐ Newspaper ☐ Health care professional ☐ Yellow pages

Other _____ (please specify)

Help us help you! Please answer the following foot questions:

Your foot problems involve:

☐ Right Foot Only ☐ Left Foot Only ☐ Both Feet

Why are you here today, explain your current foot problem(s):

_____

_____

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

Have you had medical treatment for this problem? ☐ Yes ☐ No

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

☐	Back / Knee pain	☐	Gout	☐	Warts	☐	Corns/Callouses	☐	Broken foot/leg bones
☐	Flat feet	☐	High arch	☐	Ankle injury	☐	Neuroma	☐	Childhood Foot Problems
☐	Heel pain	☐	Bunions	☐	Ingrown nails	☐	Hammertoes	☐	Others

If you've had foot x-rays when were they taken?_____

What is your current: Height: _____ Weight: _____ Shoe Size: _____

On average how much are you on your feet? (Circle one)

☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

What type of footwear do you wear most for work or leisure? (Circle one)

☐ Safety shoe/boot ☐ Athletic ☐ Dress ☐ Sandal ☐ Other_____

Do you currently use orthotics (shoe inserts)? _____

Circle any sports or activities you participate in regularly:

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

Other: _____

Do you have or have you ever been treated for:

Diabetes: Type 1 ☐ Type 2 ☐		Do you smoke? How long?	
☐	Heart Trouble	☐	Skin Disorder
☐	Hepatitis	☐	Thyroid Problem
☐	Liver Disease	☐	HIV/AIDS
☐	Urinary Problem	☐	Blood Disease
☐	Stroke	☐	Stomach/Bowel Trouble
☐	Depression	☐	Anxiety
☐	High Blood Pressure	☐	Bone Disease
☐	Cholesterol	☐	Arthritis
☐	Cancer	☐	Epilepsy
☐	Shortness of Breath	☐	Tuberculosis
☐	None apply	☐	Other:

Your current prescription medications:

Do you have any known allergies to:

Local anesthetics? (E.g. Xylocaine, Novocaine)	Yes	No
Adhesive tape/Band-Aids?	Yes	No
Other allergies:		

Do you or are you

Slow to heal after cut?

Bruise easily?

Currently pregnant or nursing?

Currently on blood thinners?

Patient Physicians & Medical Specialists:

Family Physician:

Phone:

Has your doctor treated your foot condition? Yes / No

Other Doctor's / Health Care professional name:

Type of Doctor

Phone:

Did this doctor refer you to us? Yes / No

Patient's Consent:

- I hereby consent to examination and treatment by the Podiatrist and/or support staff, also to allow photographs of treatment areas to be taken for the purposes of monitoring.
- I consent/allow the Podiatrist to contact my physician for any pertinent information required relating to my treatment or medical information.
- I consent/allow the Podiatrist to send my physician or health care professional a report regarding my foot exam and treatment plan.
- I hereby request and consent to the performance of a podiatry examination and other podiatry procedures, including various modes of palliative care, physical, surgical and orthotic therapy and, if necessary, diagnostic x-rays, on me by the Podiatrist and/or anyone working in this clinic authorized by the Podiatrist.
- I further understand and am informed that, as in all health care, in the practice of podiatry, there are some very slight risks to treatment including, but not limited to, post-op infections. I wish to rely on the Podiatrist to exercise judgment during the course of the procedure which the Podiatrist feels at the time, based upon the facts then know, is in my best interests.
- I understand that I am financially responsible for all charges whether covered by my health insurance plan or not.
- I understand that service fees are payable at the time service is provided.

Patient's Signature (or guardian): _____**Date:** _____

We promise to treat your personal information with respect. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.