



4789 Yonge Street
Toronto, Ontario
N2N 0G3

First Name	Last Name
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General Information

Gender: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth (MM/DD/YYYY)	
Street Address		
City	Province	Postal Code
Home Phone	Mobile Phone	Work Phone
Email Address (for appointment reminders only)		
How did you hear about Thornhill Foot Clinic? <input type="radio"/> Google <input type="radio"/> Yelp <input type="radio"/> Opencare <input type="radio"/> YellowPages <input type="radio"/> Other (please specify):		

Emergency Contact

Name	Relationship
Primary Phone	Alternate Phone

Other Information

Shoe Size	Weight	Height
Occupation		
Family Doctor	Doctor's Phone	
Doctor's Address		

Please turn over to complete the reverse side.

Chiropody Assessment Form

Current Issue (please select all that apply)

<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Fungal Infection	<input type="checkbox"/> Painful Feet
<input type="checkbox"/> Callus / Corn	<input type="checkbox"/> Hard to Cut Nails	<input type="checkbox"/> Warts
<input type="checkbox"/> Diabetic Foot Care	<input type="checkbox"/> Ingrown Nail	<input type="checkbox"/> Foot Injury
<input type="checkbox"/> Other (Please describe)		

Medical History (please select all that apply)

<input type="checkbox"/> Good General Health	<input type="checkbox"/> Diabetes, Number of Years:
<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Other Heart Diseases	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Neuromuscular Disorder
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Skin Condition:
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Polio / Post Polio	<input type="checkbox"/> HIV
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Other Communicable Diseases:	
<input type="checkbox"/> Surgeries (Please List All):	
<input type="checkbox"/> Fractures (Please List All):	
<input type="checkbox"/> Other:	

Current Medications:	All Allergies:

This is to certify that I, the undersigned, have correctly and accurately completed the above form to the best of my knowledge. I also consent to the performing of the chiropody procedures agreed by myself and the attending chiropodist to be necessary and advisable. I am fully aware that there is a fee for this chiropody service and I am responsible for any costs incurred.

Signature	Date
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