



CONSENT TO EXAMINATION, TREATMENT AND DIAGNOSTIC PROCEDURES

Name: _____

Date of Birth: _____

Date: _____

1. I authorize chiroprapist Robert Nekrasas, D. Ch., to perform examinations, treatments and diagnostics procedures within the scope of practice as outlined by the College of Chiroprapist of Ontario. I also understand that authorized personnel may assist him in performing these procedures
2. I also consent to such additional or alternative diagnostic, operative or treatment procedures as in the opinion of the medical staff performing the procedures mentioned are considered incidental to, or immediately necessary and vital to health and life of the patient.
3. I agree to the retention by Robert Nekrasas, D. Ch. for the diagnosis, research, teaching or therapy or the disposal in accordance with the accustomed practice any material that may be removed during procedures.
4. I acknowledge that there may be a charge applied by the chiroprapist for the consultation, visit and treatment. I agree to pay all charges in full when they are applied _____ (initials)
5. I give my permission for relevant medical information to be shared between my family physician, insurance company and the "The One" Foot Clinic & Orthotic Centre _____(initials)
6. I certify that all the information I provide is complete and accurate _____ (initials)
7. We do not disclose any information contained in patient files without the strict written consent of the patient.

Signature of Patient: _____

Media Release form



- I, the undersigned, do hereby consent and agree that "The One" Foot Clinic & Orthotic Centre, its employees, or agents have the right to take photographs of my feet for research and advertising purposes in any and all media, now or hereafter known.

I do hereby release to "The One" Foot Clinic & Orthotic Centre, its agents, and employees all rights to exhibit his work in print and electronic form publicly or Privately.

I understand that there will be no financial or other remuneration for recording me.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

- I DO NOT give consent for any pictures of my feet to be take.

Printed Name

Signature

Date

P A T I E N T

Last Name: _____ First Name _____

Date of birth: _____ Gender: _____

Address: _____

City: _____ Postal Code: _____

E-mail: _____ Occupation: _____

Phone: (H) _____ (C) _____ (W) _____ ext _____

Family Physician: _____ Dr's tel.: _____

Weight: _____ Height: _____ How did you hear about our office: _____

INSURANCE INFORMATION:

Name of company: _____ Policy No.: _____ ID: _____

Medical Information

Do you have Diabetes? Y _____ N _____ Do you have Neuropathy? Y _____ N _____

Are you in good health?Y _____ N _____

Have you been under a physician's care in the last two years? Y _____ N _____

Have you ever had severe chest pains or shortness of breath?Y _____ N _____

Are you subject to prolonged bleeding?Y _____ N _____

Have you ever fainted or passed out in a doctor's office?Y _____ N _____

Do you have low back pain?Y _____ N _____

Are you currently pregnant?Y _____ N _____

Do you now or have you ever smoked? Y _____ N _____

Which hand do you most often use?R _____ L _____ B _____

Have you had any major operations? _____

Have you ever been treated for any of the following?

- | | | | | | |
|-------------|---------------|-------------|------------------------|-----------|------------------|
| Heart | Kidney | Asthma | Phlebitis | Epilepsy | Anemia |
| Liver | Cancer | Ulcers | Gout | Arthritis | Clotting |
| Parkinson's | Scarlet Fever | Rheum Fever | High BP | Low BP | Healing Problems |
| AIDS | Thyroid | Psoriasis | Blood borne infections | | TB |

Podiatric Information

- Do you ever have foot or leg **cramps**?Y_____ N_____
- Do you ever get **numbness** in your feet or toes?Y_____ N_____
- Do you ever get **tingling** in your feet or toes?Y_____ N_____
- Have you ever had any **itching** in your feet?Y_____ N_____
- Have you ever had any major foot or **leg injuries**?Y_____ N_____
- Have you ever had any foot or **leg surgery**?Y_____ N_____
- Do or did **your parents** ever have any foot problems?Y_____ N_____
- Do your feet **perspire** excessively?Y_____ N_____
- Are your feet excessively **dry**?Y_____ N_____
- Do your feet have a strong **odour**?Y_____ N_____
- Do you treat your own feet or cut your own **callouses**?Y_____ N_____
- Can you see the soles of your feet?Y_____ N_____
- Have you ever had your feet treated **before**?Y_____ N_____
- By a Podiatrist_____ Chiropodist_____ Orthopedic Surgeon_____ Pedicurist_____ Other_____
- Do you generally find your feet to be.....Hot_____ Cold_____ Normal _____

History

- What is **your specific** foot problem? _____
- How long** have you had this problem? _____
- What have you **done** about it? _____
- Has this condition been seen by your **family doctor**? _____
- Or **other clinician**? _____
- Result of this care? _____
- Does this problem affect your walking or **normal functioning**? _____
- How much? _____

P A T I E N T

What type of pain is it?

- Sharp Bruised Aching
Dull Throbbing Hot
Sore Stabbing Tender
Numb Burning Other

Onset

- Sudden Gradual
Constant Intermittent

When does pain occur?

- Upon Walking On Standing
During Walking Lying in Bed
After Walking Spontaneously
During work Fancier Shoes
After Work Always Present
On Contact Comes & Goes

Duration

- < than 1 week >6 months
1 to 2 weeks >1 year
1 Month >3 years
1 to 3 months >5 years
>3 months Always

Other Complaints

- Legs _____
Knees _____
Hips _____
Back _____
Usage _____

Sports and Activities

- Tennis Walking
Squash Gardening
Racquetball Dancing
Badminton Skating
Cycling Skiing
Exercises Aerobics
Swimming Running
Golf Other _____

Allergies

- Aspirin _____
Cortisone _____
Sulphas _____
Codeine _____
Novocaine _____
Penicillin _____
Erythro. _____
Tape _____
Other _____

Medications: Please list / provide list

