

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 Upper James Foot Clinic.
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: _____

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: _____

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 B	Low BP	Healing Problems
AIDS	Thyroid	Psoriasis	Blood borne infections		TB

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 _____

Insurance Information

Do you have insurance coverage?

Yes No

If yes, what is the name of your insurance company?

Policy No. _____

ID No. _____

Do we have your permission to call your company to check your coverage for you?

Yes No initial _____

Allergies

Aspirin _____

Cortisone _____

Sulphas _____

Codeine _____

Novocaine _____

Penicillin _____

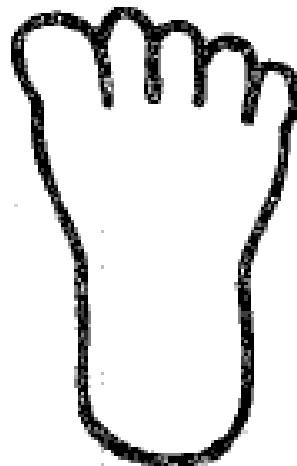
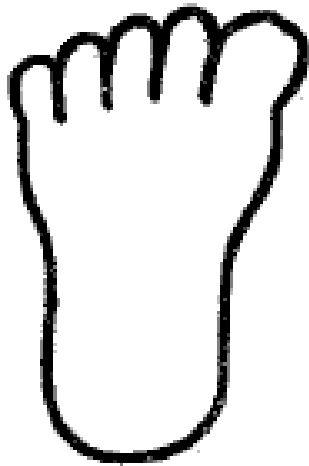
Erythro. _____

Tape _____

Other _____

Medications: Please list

P A T I E N T

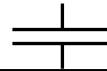


Forefoot:

- Valgus
- Varus
- Overcomp
- Subcomp

Hallux df R. . . .

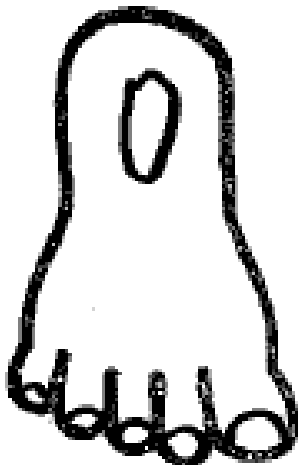
Hallux df L. . . .



Ankle D.F

R=.

L=.



D.Dx: _____ D.Dx: _____

Dx: _____

Tx Plan: _____

Rx: _____ RTC: _____

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_____
- 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 _____
- When walking, do you.....Toe In_____ Toe Out_____ Walk Straight_____

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? _____

Orthopaedic, Joint Mtn strng weak paresis

<u>Muscle Power</u>		R	=	L	
Ankle dor-fl	p w	S	=	S	w p
Ankle pla- fl	p w	S	=	S	w p
Toes	p w	S	=	S	w p
Toes	p w	S	=	S	w p
aD duction	p w	S	=	S	w p
aB duction	p w	S	=	S	w p

<u>Range</u>		R	<	>	L	=
Adduction		R	<	>	L	=
Abduction		R	<	>	L	=
Pronation		R	<	>	L	=
Supination		R	<	>	L	=
Eversion		R	<	>	L	=
Inversion		R	<	>	L	=

Arch Cavus Planus Normal

Motion Rigid Flaccid Normal

Footgear Run Lace Slip-on Heel

Heel Height 1" 2" 3" 4" 5"

Wear Pattern: Heel Md Lt ForeF Md Lt

Leg Length	R	<	>	L	=
Foot Length	R	<	>	L	=
Foot Width	R	<	>	L	=

Nails:

O/M: R5 R4 R3 R2 **R1** **L1** L2 L3 L4 L5

O/M sev R5 R4 R3 R2 **R1** **L1** L2 L3 L4 L5

O/G: R5 R4 R3 R2 **R1** **L1** L2 L3 L4 L5

..... R5 R4 R3 R2 **R1** **L1** L2 L3 L4 L5

Ing,inf R5 R4 R3 R2 **R1** **L1** L2 L3 L4 L5

Neurological

<u>Reflexes</u> – Patellar	R	L	=
Achilles	R	L	=
(Babinski) Plantar	R	L	=
Palesthesia	R	L	=
Sharp/Dull	R	L	=
Touch	R	L	=
Position Sense	R	L	=

<u>Paresthesia</u> –	Toes	R	L	=
or	Fore foot	R	L	=
<u>Neuopathy</u>	Foot	R	L	=

Dermatological

Verruca:

ID Fissuring: R4 R3 R2 R1 L1 L2 L3 L4

Tinea pedis R L Plantaris Mocassin

Heels: Xeroderma Right Left

Cracking Right Left

Dermatitis: Stasis Contact WNL

Colour: Rubor Cyanotic Pallor WNL

Vascular

<u>Pulses</u>	R	L
Dorsalis Pedis	1 2 3 4 5	1 2 3 4 5
Tibialis Posterior	1 2 3 4 5	1 2 3 4 5
Capillary Return	1 2 3 4 5	1 2 3 4 5
Temp Gradient	increased	normal
Skin Texture	dry oily turgor	decr. Normal
Edema	foot, ankle, l. Leg	foot, ankle, l. leg
Varices	foot, ankle, l. Leg	foot, ankle, l. leg
Digital Hair	yes no	yes no

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