UPPER JAMES FOOT CLINIC
& ORTHOTIC CENTRE

**ROBERT NEKRASAS, D. Ch., ● Reg#960423 ● Rx# 96423**
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# CONSENT TO EXAMINATION, TREATMENT AND DIAGNOSTIC PROCEDURES

**Name:** _____

**Date of Birth:** _____

**Date:** _____

1. I authorize chiropodist Robert Nekrasas, D. Ch., to perform examinations, treatments and diagnostics procedures within the scope of practice as outlined by the College of Chiropodist 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 chiropodist 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: _____

## Insurance Information

Name of Company:_____ Policy No. _____ID No. _____

## Medical Information

**Do you have Diabetes? Y_____ N_____ Do you have Neuropathy? Y_____ N_____**

Are you in good health? .....Y_____ N_____

Do you currently have a regular physician? ..... 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

**P A T I E N T**

## 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 specifi**c 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 _____

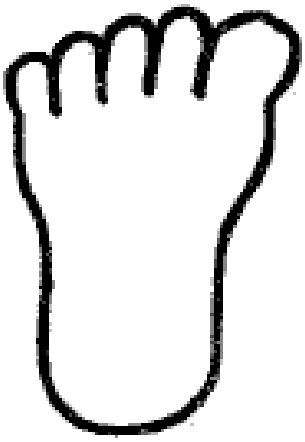
## Allergies

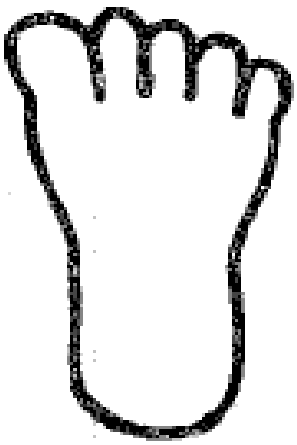
Aspirin _____
Cortisone_____
Sulphas_____
Codeine_____
Novocaine_____
Penicillin_____
Erythro._____
Tape_____
Other_____

## **Medications**: Please list

_____
_____
_____
_____
_____
_____
_____
_____

**P A T I E N T**





**<u>Forefoot</u>:**

-Valgus

-Varus

- Overcomp

- Subcomp

Hallux df R. . . .

Hallux df L . . . .

_____

Ankle D.F

R=. . . . .

L=. . . . .

D.Dx: _____ D.Dx:_____

Dx: _____

Tx Plan: _____

Rx: _____ RTC: _____

## Orthopaedic, Joint Mtn strng weak paresis

**Muscle Power** **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** |
| a**D** duction | | **p** | **w** | **S** | **=** | **S** | **w** | **p** |
| a**B** duction | | **p** | **w** | **S** | **=** | **S** | **w** | **p** |

**Range**

| | | | | | |
|---|---|---|---|---|---|
| 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

| | | | |
|---|---|---|---|
| **Reflexes** – Patellar | R | L | = |
| Achilles | R | L | = |
| (Babinski) Plantar | R | L | = |
| Palesthesia | R | L | = |
| Sharp/Dull | R | L | = |
| Touch | R | L | = |
| Position Sense | R | L | = |

| | | | | |
|---|---|---|---|---|
| **Paresthesia** – | Toes | R | L | = |
| or | Fore foot | R | L | = |
| **Neuopathy** | 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

| **Pulses** | **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 |
| Digitial Hair | yes no | yes no |

# OFFICE USE ONLY

# Release Form for Photos

I, the undersigned, do hereby consent and agree that The Upper James 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 The Upper James Foot Clinic & Orthotic Centre, its employees, or agents, all rights to exhibit this work in print and electronic form publicly or privately. I understand there will be no financial or other renumeration 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.

If the undersigned is under 18 years of age, a guardian must sign as well.

_____

Name Guardian

_____

Address

_____

Phone

_____

Witness for the undersigned

_____

Signature Date

_____

Guardian Signature