FCER-ED. 01-2015

For Office Use Only:
Notes:

FOOT CARE CLINIC REGISTRATION AND CONSENT

Thank you for participating in IDHC's Foot Care Program. Our goal is to help prevent foot care complications through education and screening.

_____ *Chiropodist /Foot Care Nurse initial*	A **Chiropodist/Foot Care Nurse** is a foot care specialist. They will do a full assessment, checking your circulation and sensitivity. They may trim your toenails and offer other treatments (such as light callus removal or ingrown toenail removal) based on your needs. If follow up is required, please ask about our subsidy program. (RUBBING ALCOHOL or TEA TREE OIL may be used) ☐ **Yes** I consent to a full assessment, basic foot care, and treatment.
_____ *Reflexologist initial*	**Reflexology** is a deep massage technique with use of oils that reduces stress and enhances circulation. You will receive a shortened session as an introduction to this service. Ointments (Cedar Wood Lotion, Olive Oil, and WITCH HAZEL) may be used. Reflexology is a detoxifying treatment, please drink plenty of water following. ☐ **Yes** I consent to a reflexology introductory session.

The personal information collected is to help identify foot care needs in Indigenous communities with in Ontario. Basic information will be summarized and made into reports for publication.

Name:	
Gender: ☐Female ☐Male ☐ Two Spirited	Age: _____ Shoe size:_____
Address:_____	Telephone: -- --
	Email:
Identify as: ☐Status Native ☐Non-Status Native ☐Metis ☐Inuit ☐Non-Native	
Home Reserve (the Band you are registered with):	

What is your diabetes status? ☐Yes___ # yrs. ☐No ☐Pre- diabetic ☐At risk(family history)

Do You Smoke? ☐Yes __ # yrs. ☐No

How much do you know about your foot care? ☐Nothing ☐Little ☐Lots

Have you attended a IDHC Foot Clinic in the past? ☐Yes ☐No

(continued on the back)

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Have you had **past** foot care services? ☐Yes ☐No

***If yes*, what kinds** of services were given?

☐Foot Care Nurse ☐Chiropodist/Podiatrist ☐Reflexology
☐Orthopaedic Surgeon ☐Pedorthic (Orthotics) ☐Other (explain):

***If yes* how often** was this care?

☐ One/Two Times ☐ As Needed ☐ Not Currently Regularly ☐ Currently Regularly

***If yes* why** did you need this care? (please explain):

Please check and explain any **health concerns** other than diabetes:

☐ Pregnant (or May Be Pregnant)
☐ Neuropathy (Nerve Damage)
☐ Retinopathy (Eye-Nerve Damage)
☐ Hypertension (High Blood Pressure)
☐ Heart Condition: _____
☐ Taking Ongoing Medication
☐ Peripheral Vascular Disease
☐ Nephropathy (Kidney Damage)
☐ Surgery
☐ Other:_____

☐ ALLERGIES:

Do you have any **foot concerns**? (Please select all that apply):

☐ No Concerns
☐ Foot Wound
☐ Ingrown Toenail
☐ Discoloured Skin
☐ Current Infection
☐ Cracked Skin/ Nail
☐ Loss of Sensation/ Numbness
☐ Bad Odour
☐ Itchy Feet
☐ Dry Skin
☐ Sweaty Feet
☐ Swelling
☐ Tingling
☐ Callus
☐ Arthritis
☐ Pain/ Tenderness
☐ Abnormalities/ Changes in Nail (i.e. Colour, Thickness, Texture)
☐ Bone Structural Change/ Concern (i.e. Bunions, Hammer Toe)
☐ Flat Feet/ Fallen Arches
☐ Wart
☐ Poor Circulation

☐ Other Concern:

Can we take your picture/videotape for our publications? ☐Yes ☐No

I hereby authorize the collection, use, and disclosure of my personal information by IDHC in order to facilitate the provision of foot care to myself for both present and future treatments, as well as for the related purposes as detailed within this registration form.

Signature/
Parental Consent:_____ Date:_____

Miigwech; Nya:wen; Thank You!

Once finished your treatments please complete an *evaluation form* and pick up your *resource kit*.☺

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