



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.

<p><i>Chiropodist /Foot Care Nurse initial</i></p>	<p><b>A Chiropodist/Foot Care Nurse</b> 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. <b>(RUBBING ALCOHOL or TEA TREE OIL)</b> may be used)</p> <p><input type="checkbox"/> <b>Yes</b> I consent to a full assessment, basic foot care, and treatment.</p>
<p><i>Reflexologist initial</i></p>	<p><b>Reflexology</b> 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 <b>(Cedar Wood Lotion, Olive Oil, and WITCH HAZEL)</b> may be used. Reflexology is a detoxifying treatment, please drink plenty of water following.</p> <p><input type="checkbox"/> <b>Yes</b> I consent to a reflexology introductory session.</p>

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: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Two Spirited	Age: _____ Shoe size: _____
Address: _____	Telephone: -- --
Email: _____	
Identify as: <input type="checkbox"/> Status Native <input type="checkbox"/> Non-Status Native <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> 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)**



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

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Foot Care Nurse     | <input type="checkbox"/> Chiropodist/Podiatrist | <input type="checkbox"/> Reflexology      |
| <input type="checkbox"/> Orthopaedic Surgeon | <input type="checkbox"/> Pedorthic (Orthotics)  | <input type="checkbox"/> 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Pregnant (or May Be Pregnant)      | <input type="checkbox"/> Taking Ongoing Medication   |
| <input type="checkbox"/> Neuropathy (Nerve Damage)          | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Retinopathy (Eye-Nerve Damage)     | <input type="checkbox"/> Nephropathy (Kidney Damage) |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Surgery                     |
| <input type="checkbox"/> Heart Condition: _____             | <input type="checkbox"/> Other: _____                |

**ALLERGIES:**

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

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

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. 😊