

Thank you for completing this form which will provide important information for me to review before we meet.

My role within the multidisciplinary team at the Crestview Medical Clinic is to provide expertise for those with **persistent foot and ankle pain.**

I am very experienced with performing skin and nail procedures of the foot, ultrasound guided diagnostic and therapeutic injections, conservatively managing chronic nerve impingement syndromes, degenerative joint, ligament and tendon disorders, and design and fabrication of CAD/CAM foot orthoses to moderate the foot and ankle stresses which can cause and perpetuate foot injury. My research area was in musculoskeletal foot and ankle sonography.

Should I make an appointment ?

YES if you have persistent foot and ankle pain, or recurring painful skin/nail conditions.

NO if you simply have difficulty managing your routine foot care.

NOTE if you have something needing urgent attention do NOT to wait for an appointment to see me before being screened by another healthcare professional.

What should I expect at my first appointment?

In addition to what is happening where you hurt I will be gathering information about your general health. This has probably been done elsewhere and because the options you have tried may have failed or not met your expectations, could understandably add to frustration over lack of progress. However, because the foot/ankle is an extremely complex region and subject to unrelenting and largely unavoidable forces, your pain may be caused by many things which need to be understood in detail. Pain may also be felt distant to the foot but associated with it and vice versa.

The initial goal will be to reasonably identify the mechanisms causing your pain. Subsequently a plan will be developed, and treatment options discussed for you to consider.

Apart from completing this form **please attend your appointment with the following:**

- 1 **All footwear** (including using at home, during sports and work) which you have used in the week before your appointment.
- 2 Any **foot orthoses, other inserts or braces** you own whether or not you are currently using them.
- 3 If your pain doesn't have an obvious pattern please keep a **log sheet of your symptoms**, for example record time pain starts, location and what you were doing and footwear during painful period, time pain finished. If there are visible signs such as change in colour or swelling **take a photo with your phone** to show me.
- 4 Request from your healthcare provider that relevant **test, Xray, MRI, scintigraphy or CT scan reports** and that your **clinical notes from other podiatrists** are faxed for my attention **before your appointment** with me.

Payment for your visit.

Podiatry fees are not currently covered by Manitoba Health. To avoid passing administrative costs on to patients we do not process insurance or credit/debit cards. If you have coverage for podiatry and/or foot orthoses with third party insurance such as Blue Cross or other insurers we will provide you with documentation to claim reimbursement. If your condition is registered as a WCB or MPIC claim we will bill those agencies directly provided that you can show **written prior approval from your case worker** for this initial consultation.

I look forward to meeting you and doing my utmost to improve your comfort.

PATIENT INFORMATION

First Name

Last Name

Date of Birth (DD/MM/YYYY)

Address

Email

Phone

Primary Care Physician

Clinic

Referred By

EMERGENCY CONTACT /NEXT OF KIN

Name

Phone

HAVE YOU EVER BEEN DIAGNOSED WITH:

Diabetes? No
 Yes

Rheumatoid Disease? No
 Yes

Circulatory problem? No
 yes

Skin Cancer? No
 Yes

PLEASE LIST

Medical Conditions

Foot or leg surgery

Medications

Others consulted
for your pain

SOCIAL/OCCUPATIONAL

- Cigarettes (Mark one only)
- I have never smoked
 - I quit less than 5 years ago
 - More than one pack per day
 - I quit more than 5 years ago
 - Less than 1 pack per day

- Alcohol (Mark one only)
- None
 - Equivalent to less than 10 glasses of wine per week
 - Equivalent to more than 10 glasses of wine per week
 - Equivalent to more than 20 glasses of wine per week

- Occupational posture (Mark one only)
- Constantly sitting
 - Mostly standing
 - Walking and lifting/carrying
 - Mostly sitting
 - Mostly walking but not lifting
 - Other

- Exercise (Mark as applicable)
- None by choice
 - Is restricted because of pain
 - Was stopped because of pain
 - Walk less than 15 minutes daily
 - Walk less than 30 minutes daily
 - Walk more than 30 minutes daily
 - Other
 - Run less than 3 days per week
 - Run more than 3 days per week
 - Marathons
 - Hiking
 - Weekend athlete
 - Elite athlete
 - Soccer
 - Impact aerobics

Start of pain and how often ?

- Initial onset Sudden Gradual

- Less than 4 weeks
- Less than 3 months
- Less than 6 Months
- Less than 1 year
- Less than 5 years
- More than 5 years

- Pain felt
- over 10X daily
 - less than 10X daily
 - less than 10X weekly
 - less than 10X monthly
 - constantly
 - constantly only standing

Pain started soon after Sudden trauma Changing job
 Changing activity level Changing footwear
 Other

Location Toe(s) Foot Leg Left Right
 Other

My pain has the following qualities: (Mark all applicable)

Burning Aching Sharp
Dull Constant Episodic
Radiating Stabbing Tingling
Throbbing Frozen Nauseating
Moves around Localized Diffuse

I typically have pain

taking first steps after sleeping Never For less than 5 minutes
 For less than 30 minutes For less than 60 minutes
 More than 1 hours For rest of day

Resting No Yes Falling asleep No Yes Standing No Yes

Walking No Yes Barefoot No Yes Wearing shoes No Yes

(If applicable) pain typically present when:

Running No Yes Using orthosis /brace No Yes NOT using orthosis /brace No Yes

WORSE PAIN OVER THE PAST WEEK?

- (Mark only one choice)
- 0 I have had no pain
 - 1 My pain was hardly noticeable
 - 2 Pain was present only if I paid attention to it
 - 3 I have been able to mostly ignore the pain
 - 4 I have been constantly aware of pain but didn't restrict activities
 - 5 I have thought about the pain most of time and it limited my activity a little
 - 6 Pain has constantly bothered me and I have limited my activity because of it
 - 7 I was unable to do most of my activities because of the pain
 - 8 Pain was severe enough to limit my concentration, speaking and listening were difficult
 - 9 Pain was so severe that I could barely talk or move
 - 10 I couldn't move and needed someone to take me to urgent care

LEAST PAIN OVER THE PAST WEEK?

- (Mark only one choice)
- 0 I have had no pain
 - 1 My pain was hardly noticeable
 - 2 Pain was present only if I paid attention to it
 - 3 I have been able to mostly ignore the pain
 - 4 I have been constantly aware of pain but didn't restrict activities
 - 5 I have thought about the pain most of time and it limited my activity a little
 - 6 Pain has constantly bothered me and I have limited my activity because of it
 - 7 I was unable to do most of my activities because of the pain
 - 8 Pain was severe enough to limit my concentration, speaking and listening were difficult
 - 9 Pain was so severe that I could barely talk or move
 - 10 I couldn't move and needed someone to take me to urgent care

I _____ (PRINT NAME) authorize Dr Martin Colledge to:

- 1 Store and protect my health information electronically in accordance with the Personal Health Information Act (<https://www.gov.mb.ca/health/phia/index.html>).
- 2 Request relevant medical records from other healthcare providers on my behalf.

I understand that podiatry fees are not covered by Medicare and that it is my responsibility to pay for these services at each appointment.

Signature _____

Date: _____