# Confidential Application for Podiatry Treatment

Please complete all details marked with \* and email to: [podiatry@northampton.ac.uk](mailto:podiatry@northampton.ac.uk)

An appointment will then be sent to you.

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| --- | --- | --- | --- |
| Clinic Stamp: (Office use only) | Date form received:Appt Date: Time: (Office use only) | | |
| Patient details | | | |
| \*Mr/Mrs/Ms/Child/Other (please circle) | \*Name: | | \*Surname: |
| \*Address  \*Postcode:  \*Email address:        Would you like correspondance sent by post or email?     Post/Email | | | |
| \*Date of Birth: | \*Contact Number: | | \*Mobile Number: |
| \*Emergency contact | | | |
| \*Mr/Mrs/Ms/Child/Other (please circle) | \*Name: | | \*Surname: |
| \*Address  \*Postcode: | | | |
| \*Contact Number: | \*Mobile Number: | |  |
| \*Doctors details | | | |
| \*GP Name: |  | | |
| \*Surgery Address:  Postcode:  Contact Number: | | | |
| \*Podiatry/Chiropody Problem | | | |
| \*Where on your foot does it hurt/cause a problem? (e.g. Pain in heel of the right foot) | | | |
|  | | | |
| \*Mark with an X where on the foot it hurts | | | |
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| --- | --- | --- | --- | --- | --- | --- |
| \*Details and medical history of your foot problem: | | | | | | |
| \*How long have you had this problem? (Days/Weeks/Years?): | | | | | | |
| \*Is your problem painful? Yes / No | | If Yes, is it: Mild / Moderate / Severe | | |  | |
| \*Are there any signs of: Redness / Weeping / Swelling / Heat / Bleeding / None | | | | | | |
| \*Have you received any medical treatment for this problem? Yes / No  If Yes, Please give details | | | | | | |
| \*Are you currently taking any medication? Yes / No If yes, please list all tablets and medicine that you take (check your repeat prescription) \*Do you have any known allergies? Yes / No (e.g. Penicillin, latex, local anaesthetics, car/dog hair, hay fever etc) | | | | | | |
| \*Have you seen a Podiatrist or Chiropodist in the last 2 years? Yes / No If Yes, Where did you receive this treatment? | | | | | | |
| All treatment is based on medical needs:\*Do you have or have you suffered from any of the following: | | | | | | |
|  | | | | | | |
| Condition | Yes / No | | Condition | | | Yes / No |
| Diabetes |  | | Registered blind or partially sighted | | |  |
| Circulation problems  (e.g. Raynaud’s) |  | | Special educational needs | | |  |
| Immunosuppression  (e.g. Renal problems) |  | | Congenital problems | | |  |
| Rheumatoid Arthritis |  | | Neurological e.g. Multiple Sclerosis | | |  |
| Osteoarthritis |  | | Terminal Illness | | |  |
| Stroke |  | | Dementia | | |  |
| Heart problems |  | | \*Other ailments not listed (state below) | | |  |
| A person with physical disabilities |  | |  | | |  |
|  |  | |  | | |  |
| Ethnic Origin - please circle: | | | | | | |
| A – White British | G – Mixed – Any other mixed background | | | N – Black/Black British African | | |
| B – White Irish | H – Asian Indian | | | P – Any other Black Background not stated | | |
| C – White – Any other not stated | J – Asian Pakistani | | | R – Chinese | | |
| D – Mixed – White and Black Caribbean | K – Asian Bangladeshi | | | S – Other ethnic groups not stated | | |
| E – Mixed – White and Black African | L – Any other Asian not stated | | | Z – Prefer not to state | | |
| F – Mixed White and Asian | M – Black/Black British Caribbean | | |  | | |
|  |  | | | | | |
| \*Personal Situation | | | | | | |
| \*Who currently cares for your feet? Self / Relative / Partner / Other (please specify) | | | | | | |
| If this has changed please explain why | | | | | | |
| \*Consent of Treatment | | | | | | |
| I consent to treatment, confirm the information given above is correct and agree to pay due charges for consumables.  Signature of applicant:..................................................................... Date: ..............................................  Children under 16years old require a signature from their parent or legal guardian:  Signature on behalf of child:............................................................. Date: ..............................................  Mother/Father/Guardian/ | | | | | | |
| Practitioner Notes (Office use only) | | | | | | |
| Clinic referred to: Monday Orthopaedic Podiatric medicine  Tuesday General At Risk  Wednesday Injection therapies  Thursday Routine  Friday Sports Paediatric | | | | | | |

The University of Northampton’s Podiatry Clinic, School of Health, Cliftonville Road, Northampton, NN1 5BF – 01604 893232