# **Confidential Application for Podiatry Treatment**

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

**An appointment will then be sent to you**.

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| --- | --- |
| **Clinic Stamp:** | **Date form received:**  **Appt Date: Time:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient details** | | | | |
| **\*Mr/Mrs/Ms/Child/Other [please circle]** | | **\*Name:** | | **\*Surname:** |
| **\*Address**  **\*Postcode:**  **\*Email address:**  **Would you like correspondence 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/** | | | | | | |

**The University of Northampton’s Podiatry Clinic, Cliftonville Road, Northampton NN1 5BU – 01604 893232**