# **Confidential Application for Podiatry Treatment**

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

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

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

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| --- |
| **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 / NoIf 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 / NoIf 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**