Complete FOOT CARE & ORTHOTIC CENTRE

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Carla Di Gioia,

BSc, DPM Doctor of Podiatric Medicine, Chiropodist

Patient Name: _____ Date: _____

Condition: PLEASE CHECK BOX next to each condition.

- ☐ plantar fasciitis/heel pain
- ☐ wound/ulceration
- ☐ skin/nail condition
- ☐ sports related injury
- ☐ flatfoot
- ☐ high arches
- ☐ pediatric foot condition
- ☐ custom made orthotics
- ☐ other conditon
- ☐ warts
- ☐ laser for warts
- ☐ ingrown toenail
- ☐ bunion
- ☐ hammertoe
- ☐ diabetic foot care
- ☐ onychomycois ☐ laser
- ☐ compression stockings
- ☐ night splint

Comments: _____

Physician's name & signature: _____