CompleteCare CHIROPRACTIC

Orthotic Intake Form

Personal Details

Name: _____ Gender: M F Birthday (D/M/Y) _____/_____/_____

Home Address: _____ City: _____ Postal Code: _____

Telephone (Home)_____ (Work)_____ (Mobile)_____

E-mail address _____

Emergency Contact:_____ Relationship: _____ Phone _____

Medical Doctors Name: _____ Last Visit: _____/_____/_____

How did you hear of this practice? _____

How would you like to communicate with our clinic? ☐Email ☐Cell Phone ☐Home Phone ☐Work Phone

Medical History

1. Please list all current medications (including vitamins etc): _____

_____

2. Have you ever experienced any major accidents/injuries, broken bones, or dislocations? List Details. _____

_____

3. Have you ever had any surgeries/Hospitalizations? List Details. _____

_____

4. In the past 5 years, have you had: ☐X-Ray ☐CT Scan ☐MRI ☐Ultrasound ☐ Blood Tests ☐Other

List details: _____

5. Have you ever experienced any of the follow, or other medical illnesses?

☐HIV ☐Hepatitis ☐Stroke ☐ Heart Attack ☐ Hypertension ☐Varicose Veins

☐DVT ☐Pacemaker ☐ Rheumatic Fever ☐ Pneumothorax ☐ Asthma ☐Chronic Bronchitis

☐COPD ☐ Emphysema ☐ Tuberculosis ☐ Epilepsy ☐ Multiple Sclerosis ☐Depression

☐Anxiety ☐ Polio ☐ Syphilis ☐ Meningitis ☐ Parkinson's ☐Arthritis

☐Cancer ☐Osteoporosis ☐ Kidney Stones ☐Urinary Infections ☐ Hemorrhoids ☐Thyroid Disease

☐ Diabetes ☐Anemia ☐Food Allergies ☐Seasonal Allergies ☐Other allergies: _____

☐Other conditions: _____

Family History 6. Has anyone in your family suffered from any conditions/diseases/illnesses?

☐Diabetes ☐Hypertension ☐Stroke ☐Heart Disease ☐Arthritis ☐Migraine ☐Cancer

☐Other: _____

Social History

7. Do you drink alcohol? ☐ Yes ☐ No Drinks per week: <1 1 2 3 4 5 6 7 8 9 10 >10

8. Do you smoke cigarettes? ☐ Light Smoker ☐ Heavy Smoker ☐ Former Smoker ☐ No/Never

9. Cigarette Packs per Day: <1 1 2 3 4 5 6 7 8 9 10 >10

10. Do you drink coffee/caffeine? ☐ Yes ☐ No Drinks per day: <1 1 2 3 4 5 6 7 8 9 10 >10

11. Do you exercise: ☐ No ☐ Light Exercise ☐ Moderate Exercise ☐ Strenuous Exercise

12. How many hours per week do you exercise: <1 1 2 3 4 5 6 7 8 9 10 >10

Workplace History

13. Employer: _____ Occupation: _____

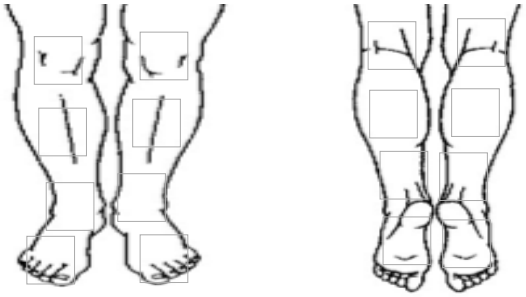
14. Please check the most accurate description of your overall work demands.

☐Sedentary (sitting) ☐Standing ☐Light Labor ☐Heavy Labor

Chief Complaint

16. Indicate the concerns that you are seeking care for today.

1. _____
2. _____
3. _____



Systems Review 17. Are you experiencing any of the following?

General	Gastrointestinal	EENT	NVS	FEMALE ONLY
☐New mole	☐Heart Burn	☐Ringing in Ears	☐Mood changes	☐Breast Lump
☐Change in Mole	☐Bloating	☐Ear Pain	☐Memory Loss	☐Mid Cycle Bleed
☐Rashes	☐Nausea	☐Balance Issues	☐Seizures	☐Irregular Periods
☐Discolorations	☐Vomiting	☐Jaw Issues	☐Sleep Issues	☐Vaginal Discharge
☐Bleeding	☐Constipation	☐Sore throat	☐Tremors/Shakes	☐Vaginal Bleeding
☐Bruising	☐Diarrhea	☐Glasses/contacts	☐Nervousness	☐Pregnant
☐Fatigue	☐Aggr. by food			☐Birth Control
☐Muscle Aches	☐Aggr. by drinks		**URINARY**	☐Hormone Therapy
☐Joint Pain		**CSV/RESP**	☐Painful Urination	
☐Weakness	**ENDO**	☐Palpitation	☐Burning	**MALE ONLY**
☐Numbness	☐Excessive Thirst	☐Cough	☐Discoloration	☐Bleeding
☐Leg Cramps	☐Change in Appetite	☐Chest Pain	☐Blood in Urine	☐Scrotal lump
☐ Leg Swelling	☐Temp Intolerance	☐Difficulty Breathing	☐Incontinence	☐Scrotal swelling

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Intake Form Acknowledgement

I acknowledge and confirm that the above information is correct and true. I also provide my consent to allow the health practitioner to perform the exams/tests that he/she deems clinically relevant to come to a diagnosis and/or plan of management. I hereby authorize Complete Care Chiropractic, with my prior knowledge, to release or to obtain any health information to/from my other health care providers as may be required for the diagnosis/management of my case. **To be signed after consultation.

Sign:_____ (Patient/Guardian) Date:_____ / _____ / _____

Informed Consent to Custom Orthotic Therapy

Important Aspects to Note

Custom orthotics are a medical device designed to support the foot and ankle resulting in improved foot biomechanics, better pressure distribution and better shock absorption. Custom orthotics have also shown to alter muscle activation and joint biomechanics higher up in the kinematic chain (knee, hip, low back etc). As a result, custom orthotics can be quite effective to relieve/prevent/slow progression of pain and dysfunction in the foot, ankle, knee, hip lower back etc.

Although custom orthotics can control the integrity of the foot and ankle, they do not change the underlying structure of the adult foot. They must be worn to exert their effects. If they are not worn, pain and dysfunction can and will return.

As with all therapies there are risks associated with custom orthotic therapy. Due to the change in foot biomechanics, it is quite common to experience temporary discomfort, aches, pains and stiffness during the initial stages of care. Likewise, a change in balance is also common. We recommend a transition period. Start by wearing your orthotics for 15-20 minutes/day increasing accordingly based on tolerance.

Alternatives to Custom Orthotic Therapy.

There are other alternatives to custom orthotics including seeking medical advice, massage therapy, physiotherapy, acupuncture etc. However, keep in mind all therapies have their own risks associated with them. You also have the option of doing nothing. Although the symptoms have a tendency to improve without treatment, this is not advised as there is an increased chance of re-occurrence in the future.

Custom Orthotic Fees

I understand there are fees associated with custom orthotics. These fees have been discussed with me. This covers, the biomechanical examination, casting, the custom made orthotic(s) and the dispensing fee. I agree to this proposed fee schedule and understand that I am responsible for payment of these fees. We recommend that you check with your insurance provider, as a portion of cost or the entire cost may be covered.

Consent

I acknowledge I have read this consent and I have discussed with my chiropractor the nature and purpose of custom orthotic therapy, the treatment options and recommendations for my condition, and the contents of this consent. I understand written consent is required before treatment. I consent to the custom orthotic therapy recommended to me by my chiropractor. **To be signed after consultation.

Date: _____ / _____ / _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)

Print:_____ (Practitioner) Sign:_____ (Practitioner)