Goderich Chiropractic Health and Wellness Centre
Dr. Tricia Denunzio, D.C.
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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods. Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case.

Please complete this confidential Health Questionnaire fully and accurately. The more we know about the overall picture of your health the better we will be able to help you.

If you have any questions, please don't hesitate to ask one of our chiropractic assistants for guidance.

Patient Information

Name_____

Street Address_____ **Apt. #**_____

City_____ **Prov.**_____ **Postal Code**_____

Home Phone_____ **Cell**_____

Work Phone_____ **Ext**_____ **Fax**_____

E-mail_____

Birth date_____ **Shoe Size**_____

Height_____ **Weight**_____

Gender: ___ Male ___ Female

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced___ Widowed ___ Common Law

Your occupation: _____ Employer: _____

Name of Spouse / Significant Other_____

Who referred you to this office?_____

What is the purpose of this appointment?

Describe the purpose of this visit_____

_____

Is the purpose of this appointment related to:

_ Work _ Stress _ Sports _ Auto _ Fall _ Chronic _ Discomfort Repetitive _ Trauma
_ Check up _ Other

Please explain_____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? (when) _____

What activities aggravate your condition? _____

Has this condition _ Gotten worse _ Stayed constant _ Comes and goes

Does this condition interfere with _ Work _ Sleep _ Daily Routine _ Childcare Responsibilities
_ Sports _ Other Activities

(Please explain)_____

Have you seen any other health care providers for diagnosis or management of this condition?
_ Yes _ No (if yes please explain below)

Practitioner's Name_____ Practitioner's Name_____

Type of Care_____ Type of Care_____

Date_____ Results_____ Date_____ Results_____

My Heath Conditions (Past and Present)

Please check each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

General:
__ Allergy
__ Convulsions
__Dizziness
__Fatigue
__Headache
__ Loss of Sleep
__Loss of Weight
__Anxiety/Depression
__Numbness
__Cancer
__ Diabetes
__Thyroid Problems
__Epilepsy
__Hyperactivity

Muscle and Joint:
_ Arthritis
_ Hernia
_ Low Back Pain
_ Neck Pain
_ Pain between shoulders blades

Numbness or pain in:
__ Shoulders
__Upper arms
__ Hands
__ Legs
__ Feet
__ Poor Posture
__Swollen Joints
__Gout
__Polio
__Sinus

Gastro-Intestinal:
__ Constipation
__ Diarrhea
__Digestive Dysfunction
__Gall Bladder Trouble
__Hemorrhoids
__ Liver Trouble
__ Ulcers

Eyes, Ears, Nose, Throat:
__Asthma
__ Frequent cold
__ Crossed Eyes
__Deafness
__Ear infections
__Ringing in Ears
__ Eye Pain
__Vision Problems
__ Nasal Obstruction

Cardio-Vascular:
__ High Blood Pressure
__ Low Blood Pressure
__Poor Circulation
__ Irregular Heart Beat
__ Ankle Swelling
__ Anemia
__ Arteriosclerosis
__ Stroke

Respiratory:
__ Chest pain
__ Chronic Cough
__ Irregular Breathing
__Wheezing
__ Emphysema

Genito-Urinary:
__ Bed-Wetting
__ Painful Urination
__ Prostate Trouble
__ Blood in urine
__Venereal Disease

Women Only:
__ Menstrual Cramps
__ Excessive Menstruation
__ Irregular Cycle
__ Hot Flashes
Are you pregnant?
__ Yes __ No

Other (not listed) _____

With respect to the questions below, please provide details where applicable, including dates: (you may use the back if of this sheet if necessary)

Have you ever been knocked unconscious? _ Yes _ No _____

Have you ever used crutches, a walker, or cane? _ Yes _ No

Have you had any broken bones? _ Yes _ No _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? _ Yes _ No

_____

Sprains, strains, dislocations, and years: _____

Surgical operations and years: _____

Have you ever been hospitalized for any other reason? _ Yes _ No

Family members with diagnosed health problems:_____

Informed Consent for Chiropractic Examination and Foot Orthotic Therapy

Informed Consent form for foot orthotic therapy

Your chiropractor has prescribed medical devices for you called custom foot orthotics. Orthotics can be an integral part of patient care by heath care providers for the management of pedal pathologies and musculoskeletal symptomatology, and to alleviate pain and discomfort from abnormal foot function. Abnormal foot function may affect a patient's kinetic chain, including legs, knees, hips and spine.

Orthotics are designed based upon the degree of patient abnormal foot function, patient activity level, patient physical stature and the type of footwear in which the orthotics are worn. Custom orthotics are foot inserts placed inside footwear.

What is the process?

Your chiropractor will assess your foot function in order to determine if you require foot orthotics and if you do, what type of orthotic will benefit you most.

The next step is capturing your foot image and sending that image to a custom foot orthotic laboratory that will make a device specific to your foot. This process usually takes about 2-4 weeks.

When the orthotics arrive back at this location, your chiropractor will ensure the devices fit and function properly and your chiropractor will explain the "break in" instructions.

What should I expect when wearing the orthotics?

Many patients experience pain reduction and increased comfort when wearing custom foot orthotics. A small percentage of patients experience discomfort and/or pain when breaking in their orthotics

and an even smaller percentage of patients experience significant enough pain that they cannot wear their orthotics at all.

Consent

I have read the information above and hereby request and consent to the performance of the assessment of my foot function and the prescription of custom foot orthotics by **Dr. Tricia Denunzio.**

I have had an opportunity to discuss with **Dr. Tricia Denunzio** the nature, purpose, benefits and risks of custom foot orthotics.

I understand and am informed that, as in the practise of medicine, in the practise of chiropractic there are some risks to treatment with custom orthotics, including, but not limited to, foot pain, leg pain, back or next pain. I do not expect **Dr. Tricia Denunzio** to be able to anticipate and explain all risks and complications, and wish to rely on **Dr. Tricia Denunzio** to exercise judgement during the course of the procedures which **Dr. Tricia Denunzio** feels at the time based on the facts then known are in my best interests.

I have read and or have read to me the above consent. I have had the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present and for future condition(s) for which I seek foot orthotic treatment.

TO BE COMPLETED BY THE PATIENT
(Or by Parent or Guardian)

_____ _____
Patient Name Signature of Patient

_____ _____
Date Signed Witness Signature

Fees

Custom Orthotics	**Including Biomechanical Evaluation & Exam Casting, and/or Properietary GaitScan™ and Custom Orthotic Inserts**	**$450.00**
Shoes	**Shoes when purchased with Custom Orthotics**	**Starting at $50.00**

Disclosure for custom foot orthotics:

Name:_____

I understand that I am being cast for Orthotic group custom orthotic devices by Dr. Denunzio. The cost of these devices will be $_____, which may or may not be covered by my insurance. This clinic will issue me a receipt to submit to my insurance to cover my orthotics. The amount paid by the insurance company will be reimbursed to me. This clinic will make every effort to make these orthotics work for me **all adjustments are free** but **they are not returnable for a refund or credit.**

- ☐ Today I agree to pay the full amount of $_____ at the time of dispensing.
- ☐ I have chosen to have the custom foot orthotics rush ordered for an additional fee of $50.00
- ☐ I would like to purchase the outgrowth policy for my child for an additional $50.00. I understand that for the next two years any replacement pair of orthotics is only an additional $50.00.

Total amount paid when dispensed: $_____

Signed_____ Date_____

Witness_____ Date_____