

Goderich Chiropractic Health and Wellness Centre

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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Instructions:

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.

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.

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 Health 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

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
- Sinus

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 health 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 Proprietary 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 _____