Custom Orthotics Form

Patient Contact Information:

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Name: _____ Occupation: _____

Date of birth: _____(m/d/y) Age: _____

Address: _____ City:_____Province: _____Postal code:_____

Phone: Home _____ Cell: _____ Work:_____

Email address:_____

Emergency contact: _____ Relationship:_____ Phone:_____

How did you hear about this office?_____

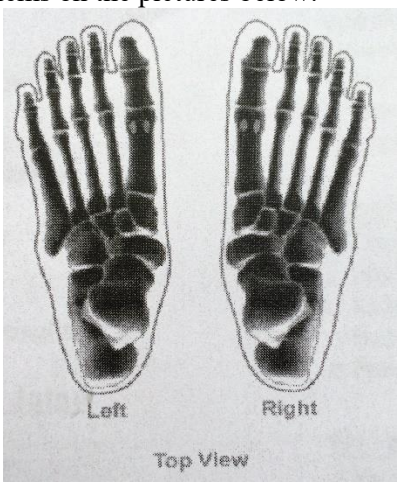
Please indicate if you experience any of the following symptoms of faulty foot mechanics :

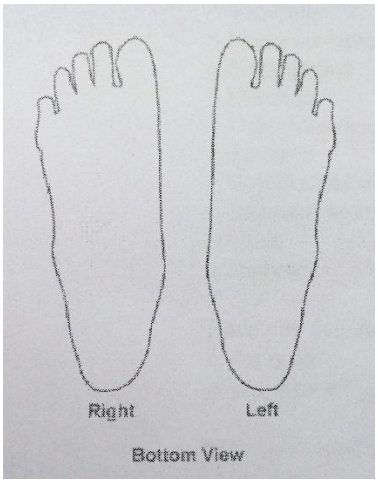
□ localized foot pain □ bunions □ calluses □ hammer toes

□ arch/heel pain □ leg/knee pain □ hip pain □ back pain

□ other symptoms:

Please label any problems on the pictures below:





What shoes do you wear most often? _____

What shoes are the most comfortable? _____

How many hours do you spend on your feet each day? _____

Have you worn orthotics before? _____

What is your primary concern about your feet? _____

What do you hope to achieve in this visit today? _____

I consent to and request an examination of foot function to determine the need for custom orthotics.

I understand that should I require orthotics, I am responsible for the payment and the payment is due upon ordering them. Supplemental or extended health care insurance may provide coverage for orthotic therapy, however it is my responsibility to determine the extent of my coverage and if there are any special requirements or exclusions. A receipt will be issued for the payment to facilitate reimbursement. I understand that I will not be refunded by Dr. Miron should my insurance deny reimbursement.

_____ _____

Patient/Guardian Signature Date

Dr. Elisabeth Miron, Chiropractor - 126 Temperance St, Unit 1 - Aurora – ON – L4G 2R4 – (647)478-9323 – ***www.MironDC.ca***

Health Status Survey

Patient Name: _____ File #: _____ Date: _____

Please **X** the box for any conditions or symptoms **presently** causing you problems.
Please check **(√)** the box for those conditions or symptoms **that you have had in the past.**

General Symptoms
□ Loss of Consciousness
□ Blackouts
□ Headache
□ Fever
□ excess sweating
□ Night sweats
□ Loss of weight
□ Night pain
□ Generalized pain
□ Nervousness
□ Convulsions
□ Loss of sleep

Neurologic
□ Dizziness
□ Fainting
□ Problem speaking
□ Problem swallowing
□ Blurred vision
□ Double vision
□ Nausea
□ Clumsiness
□ Numbness or tingling

Muscles and Joints
□ Neck pain
□ Mid back pain
□ Low back pain
□ Tailbone pain
□ Shoulder pain
□ Arm / forearm pain
□ Elbow pain
□ Wrist / hand pain
□ Hip pain
□ Knee pain
□ Ankle / foot pain
□ Arthritis
□ Loss of strength

Eyes/Ears/Nose/Throat
□ Failing vision
□ Eye pain
□ Failing hearing
□ Earache
□ Ring/buzz in ears
□ Sinus infection
□ Enlarged thyroid
□ Enlarged glands

Respiratory
□ Asthma
□ Chronic cough
□ Spitting up phlegm
□ Spitting up blood
□ Difficulty breathing

Cardiovascular
□ Bleeding disorder
□ High blood pressure
□ Chest pain
□ Stroke
□ Hardening of arteries
□ Varicose veins
□ Swelling or ankles
□ Poor circulation
□ Heart / blood disease
□ Angina

Genitourinary
□ **Trouble urinating**
□ **Blood in urine**
□ **Kidney infection**
□ **Bed wetting**
□ **Prostate trouble**

GU for Women
□ **Painful menstruation**
□ **Excessive flow**
□ **Hot flashes**
□ **Irregular/absent cycle**
□ **Cramping/backache**
□ **Vaginal discharge**
□ **Swollen breasts**
□ **Lump in breasts**

Currently on birth control pills/patch? □ yes □ no

Previously on birth control pills/patch? □ yes □ no

# of pregnancies:
# of children:

Skin
□ Rashes/itching
□ Bruise easy
□ Dryness
□ Boils
□ Hives (allergies)

Gastrointestinal
□ Poor appetite
□ Indigestion
□ Excess hunger
□ Belching or gas
□ Vomiting
□ Pain over stomach
□ Constipation
□ Diarrhea
□ Hemorrhoids (piles)
□ Jaundice
□ Gall bladder trouble
□ Intestinal worms
□ Ulcer
□ Diabetes

Have you ever had any fractures?
□ yes □ no
If yes, where?

Have you ever been in a car accident?
□ yes □ no
If yes, when?

Have you ever been hospitalized?
□ yes □ no
Why? When?

Are you currently a smoker?
□ yes □ no
How much?
Did you smoke previously?
□ yes □ no
How much?

Have you ever been diagnosed with:
Cancer? □ yes □ no
HIV/AIDS? □ yes □ no
Hep A/B/C? □ yes □ no

Medications (list):

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