HANDLEY PEDORTHIC CLINIC PATIENT FORM

Contact Information:

Name: _____ Birth Date: (M) _____ / (D) _____ / (Y) _____

Address: _____ City: _____ Postal Code: _____

Phone Number: _____ Email: _____

Preferred Method of Contact: □ Phone □ Email

Workplace: _____ Occupation: _____

Medical Doctor:

Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

How did you learn about our clinic?

□ Patient: _____ □ Other Health Care Provider: _____

□ Google □ Social Media □ Front Sign □ Other: _____

Personal Health History:

What is your reason for attending our clinic today? _____

Height: _____ Weight: _____ Shoe Size: _____

Do you currently wear:

□ Heel Lifts □ Arch Supports □ Over-The-Counter Orthotics □ Custom Orthotics

If yes, to custom orthotics, how old are they? _____ How many pairs do you have? _____

Where were they made? _____ Did you have success with them? □ Yes □ No

If you are not currently wearing orthotics, have you worn orthotics in the past? □ Yes □ No

Please select which type of footwear that you primarily wear:

□ Casual Shoes □ Loafers □ Running Shoes □ Walking Shoes □ Work Boots

□ Dress Shoes □ Heels □ Sandals □ Boots □ Slippers

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In the past, or at present do you have:

- ☐ Heel Pain
- ☐ Arch Pain
- ☐ Forefoot Pain
- ☐ Ankle Pain/ Trauma
- ☐ Knee Pain/ Trauma
- ☐ Back Pain
- ☐ Hip Pain
- ☐ Bunions
- ☐ Plantar Fasciitis
- ☐ Metatarsalgia
- ☐ Achilles Tendonitis
- ☐ Calluses
- ☐ Corns
- ☐ Shin Splints
- ☐ Diabetes
- ☐ Circulatory Disorders
- ☐ Patellofemoral Syndrome
- ☐ Iliotibial Band Syndrome
- ☐ Numbness in Toes
- ☐ Hammer/ Claw/ Mallet Toes
- ☐ Pins and Needles in Toes
- ☐ Flat Fleet
- ☐ High Arches
- ☐ Arthritis (Foot/Ankle/Knee/Hips/Back)

Have you had any previous injuries, trauma, or surgeries on your feet/ankle/knees/hips/back?

☐ Yes ☐ No If yes, please list the surgical procedures and dates: _____

_____

What are your occupational demands? _____

Approximately how many hours a day are spent: Standing _____ Walking _____ Sitting _____

Sports and Recreation:

What is your level of activity: ☐ Recreational ☐ Competitive

How much time do you spend participating in athletic activities per week?

☐ <3 hours ☐ 3-6 hours ☐ >6 hours

Please list the type of athletic activities you engage in on a regular basis:_____

_____

If you are a runner, please indicate:

How often you run _____ Average distance _____

Running shoe type _____ Running shoe age _____

Additional Information:

Do you require a prescription for custom orthotics and/or compression socks?

☐ Yes ☐ No

Do you have extended health care coverage for custom orthotics and/or compression socks?

☐ Yes ☐ No

Would you like additional information about the chiropractic services offered at this clinic?

☐ Yes ☐ No

The information collected on this form is in accordance with the Standards of Practice as outlined by the Canadian College of Pedorthics.

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Consent to Pedorthic Treatment

I hereby authorize Handley Pedorthic Clinic Inc. to the biomechanical assessment, gait analysis, casting procedures, techniques and clinical photographs that the pedorthist in attendance deem necessary for my care.

I understand that prior to any diagnostic procedure, technique, or taking of any clinical photograph or video, I will be advised by the pedorthist responsible for the care, and that I may ask questions concerning treatment. I also understand that custom foot orthoses work in conjunction with proper footwear and I agree to abide by any recommendations made with regard to specific shoe features in the pedorthic treatment plan. I further understand that I may revoke this consent before such treatment is provided.

I hereby authorize and consent Handley Pedorthic Clinic Inc., to release to government agencies, insurance carriers, or others who are financially liable for pedorthic care, all information needed to substantiate payment for such care, and permits others who are representatives thereof to examine and make copies of all records relating to such care and treatment. However, after disclosure has been made, it cannot be revoked retroactively to cover information prior to revocation.

I understand this consent will remain in force until I revoke it in writing.

I hereby state that I have read and understood this consent form, and that I have been given the opportunity to ask questions I might have, and that all my questions have been answered in a satisfactory manner.

Patient Name: _____

_____ _____

Patient Signature Date

_____ _____

Pedorthist Signature Date