Dr. Douglas Vlaskamp, D.C., Clinic Director, Chiropractor, Laser Therapist
Dr. Rishi Tayal, D.C., Chiropractor, Laser Therapist, Spinal Decompression Specialist
118 Queen St. West, Suite 205, Brampton, ON, L6X 1A5 905-451-3963

New Patient Form - Orthotic

PERSONAL INFORMATION

Last Name:_____ First Name:_____

Birth Date: _____ /_____ / _____ Age: ____ Gender: M/F Height:____ Weight:_____ Shoe Size:____
(DAY / MONTH / YEAR)

Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email address: _____

How would you like to be reminded of appointments? Home____ Cell ___ Work___ Email___

How did you hear about us? Family___ Friend ___ Internet ___ Doctor ___ Advertising ___

EMERGENCY CONTACT

Last Name:_____ First Name:_____

Relationship: Parent____ Relative ___ Friend___

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

CONSENT TO BE EXAMINED BY THE CHIROPRACTOR

I consent to be examined by the chiropractor to help with my treatment. Examination may consist of range of motion tests, orthopedic tests, and hands on assessment of joint mobility and/or muscle tension or weakness. The Chiropractor will explain the steps of the examination. I understand that I may withdraw consent at any point and will let the Chiropractor know if I do not want him to proceed with the examination. Date: _____

PATIENT NAME:_____ (PLEASE PRINT) PATIENT SIGNATURE:_____ (OR PARENT/GUARDIAN IF UNDER THE AGE OF 16)

DC'S NAME:_____DR. DOUGLAS VLASKAMP / DR. RISHI TAYAL_____ DC'S SIGNATURE: _____

DESCRIBE YOUR FOOT COMPLAINT

Do you have foot pain? Right foot_____Left foot_____

Area(s) involved: Arch___ Heels___ Bottom of foot___ Toes___

Is this condition: New___ Recurrence___ Exacerbation___ Chronic___

Do think your foot pain might be affecting other parts of your body? Ankles ___ Knees ___ Hips ___ Back ___ Neck ___

How active are you? Sedentary___ Average____ Athletic____

Have you had orthotics before? Y/N If yes, how long since last pair?_____

Use the letters below to indicate TYPE and LOCATION of your sensations right now:

A=Aching

B=Burning

N=Numb

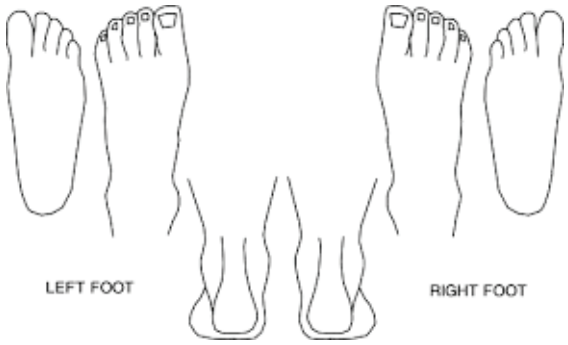
P=Pain

PN=Pins & Needles

ST=Stabbing

S=Stiffness

W=Weakness



Level of pain at REST: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Level of pain while ACTIVE: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Feels worse in the: Morning___ Afternoon___ Night ___

Feels worse with: Activity___ Sitting___ Standing___ Twisting___ Bending___ Walking___

Are you experiencing any of these symptoms?: Localized Tingling___ Nausea___ Cold Limbs___ Joint Stiffness___

Muscle Spasm___ Muscle Weakness___ Pale Bluish Skin___

Does the pain radiate? Left___ Right___ Both Sides___ No Radiation___

Is there weakness present? Left___ Right___ Both Sides___ No Weakness___

Symptoms better with? Nothing___ OTC Meds___ RX Meds___ Cold___ Heat___ Massage___

Movement___ Sitting___ Standing___ Stretching___ Walking___

DO YOU SUFFER FROM ANY CONDITIONS OTHER THAN WHAT IS LISTED ABOVE? _____

_____

CURRENT MEDICATIONS

Medication_____Dosage_____ For Which Condition?_____ For How Long?_____

Medication_____Dosage_____ For Which Condition?_____ For How Long?_____

HISTORY OF INJURIES Check ALL Injuries and Approximate Year

Back Injury _____ MVA _____ Broken Bones _____ Head Injury (loss of consciousness) _____

Head Injury (no loss of consciousness)_____ Soft Tissue Injury (mild)_____ Soft Tissue Injury (moderate)_____

Soft Tissue Injury (severe) _____ Fall(severe) _____ Joint Injury _____

Other_____

HISTORY OF SURGERIES List ALL Surgical Procedures and Approximate Year

_____

_____

_____