



Dr. Douglas Vlaskamp, D.C., Clinic Director, Chiropractor, Laser Therapist

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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, DC, Chiropractor

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 ____

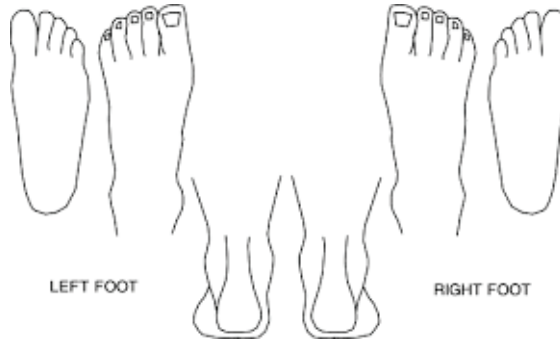
Do think your foot pain might be affecting other parts of your body? Ankles ____ Knees ____ Hips ____ Back ____ Neck ____

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

