Lakeridge Chiropractic

1291 King Street East
Oshawa, Ontario, Canada, L1H 1J2
Tel: 905-436-6688
Fax: 905-436-6690
email: office@lakeridgechiropractic.ca
www.lakeridgechiropractic.ca

New Patient Information

Today's Date: day / month / year

Personal Information

Name:	Age:	Date of Birth: day / month / year
☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner	
Spouse's Name:		Number of Children:

Mailing Address

Street:	
City:	Province:
Postal Code:	Home Phone:
Cell Phone:	Work Phone:
e-mail address (confidential):	

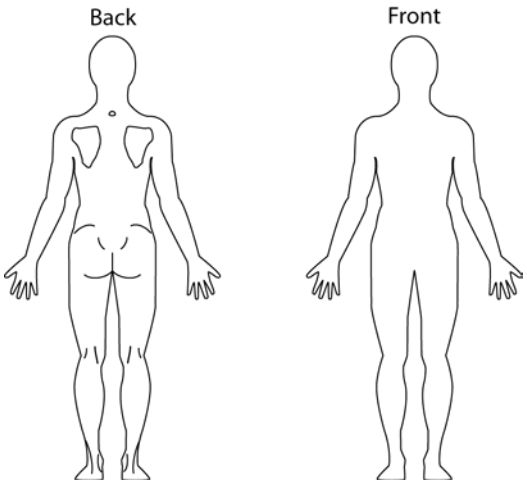
Health Care Information

Extended Health Care Insurance Provider:	
Family Doctor:	Clinic:
Address:	Phone:
*Would you like your family doctor to receive a report of your condition/progress: ☐ Yes ☐ No	

Reason for your visit

What is your primary problem?
Who can we thank for referring you to our clinic?
When did this problem begin? Date:
Were you involved in a motor vehicle accident?
Is this a WSIB injury? ☐ Yes ☐ No

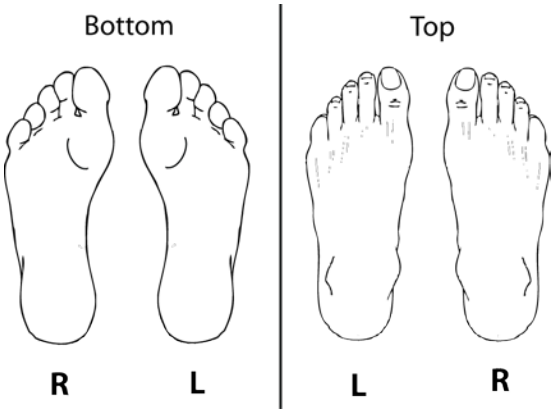
Where is your Problem?
(Mark on the diagram)



Please Rate your Pain(Circle one)

1 2 3 4 5 6 7 8 9 10

No pain — Distracting — Worst Pain possible



Lakeridge Chiropractic

1291 King Street East
Oshawa, Ontario, Canada, L1H 1J2
Tel: 905-436-6688
Fax: 905-436-6690
email: office@lakeridgechiropractic.ca
www.lakeridgechiropractic.ca

Health History (check those that apply)

Surgeries

	Surgery	Date
☐	Heel	
☐	Toes	
☐	Ankle	
☐	Knee Replacement	
☐	Knee Scope	
☐	Hip Replacement	
☐	Achilles Tendon	
☐	Spinal Surgery	

Shoe Size:
Weight:

Family History

☐	Heart/Cardiovascular Disease
☐	Stroke
☐	Diabetes
☐	Cancer
☐	Scoliosis
☐	Arthritis
☐	High blood Pressure
☐	Obesity

Medication

☐	Blood Pressure
☐	Cholesterol
☐	Diabetes
☐	Heart
☐	Arthritis
☐	Thyroid
☐	Pain
☐	Birth Control
Other	

Foot and related problems

	Condition	Date
☐	Drop Foot	
☐	Flat Foot	
☐	Tendonitis	
☐	Osteoarthritis	
☐	Shin Splints	
☐	Hammer Toes	
☐	Bunions	
☐	Post-Surgical Pain	
☐	Cancer	
☐	Heel Pain	
☐	Diabetes	
☐	Low back pain	
☐	Plantar Fasciitis	
☐	Heel Spur	
☐	Neuroma	
☐	Numbness/Tingling	
☐	Abnormal Gait	
☐	Tear/Sprain	
☐	Scoliosis	
☐	Leg Length Discrepancy	
☐	Abnormal Knee Tracking	
☐	Hip pain	
☐	Rheumatoid Arthritis	
☐	Gout	

Environment

☐	Concrete Floors
☐	Ceramic Tile
☐	Asphalt
☐	Heavy Labour
☐	Running Shoes
☐	Skates
☐	Soccer
☐	Golf Shoes
☐	Office/dress Shoes

Lakeridge Chiropractic

Dr. Peter Wysotski Dr. Adam Wysotski
1291 King Street East, Oshawa, ON, L1H 1J2
Phone: 905-436-6688 Fax: 905-436-6690
office@lakeridgechiropractic.ca

Informed Consent for Custom Orthotics

Doctors of Chiropractic who prescribe custom foot orthotics are advised to inform and discuss with patients the rationale for their prescription.

Each patient is individually assessed for the clinical benefit that custom foot orthotics may provide. In each case, biomechanical correction is aimed at improving function and relieving pain. Therapeutic benefit is hoped, but not assured.

Some patients report some discomfort when first wearing their orthotics. This discomfort can occur in the feet, legs, knees, hips and or lower back. These aches are usually transitory, and usually disappear in time as the body adjusts to alignment and functional changes.

It is not unusual for the orthotics to slip a little, particularly if they are placed into slip-on shoes. In most cases, this will disappear as foot function improves, and the orthotics settle into the appropriate footwear.

Each patient is given a handout advising of the proper introduction of the orthotics into their footwear and into their daily routine. Custom foot orthotics are aimed at improving shock absorption and biomechanics, and are often recommended in conjunction with other therapeutic modalities to alleviate pain and dysfunction. It is recommended that patients follow up with the chiropractor two to four weeks after receiving the orthotics, to assure a smooth and satisfactory transition to therapeutic benefit.

I consent to custom foot orthotics recommended by my chiropractor. I have had an opportunity to discuss the nature and purpose of this therapeutic modality.

Name: (please print)	
Signed:	**Date:**
Witness Name: (please print)	
Witness Signature:	