Bow Valley Chiropractic

Orthotics intake

email: admin@bowvalleychiro.com
Ph: 403.262.2211

Name: _____ Date: _____

Address: _____ Postal code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Date of Birth: _____

Shoe Size: _____ Height: _____ Weight: _____

Referring doctor/health professional: _____ AB Health care#: _____

Do you have a written referral with you? Yes/No

Medical History:
Please **circle** if you have:

Diabetes Type ___	Rheumatoid arthritis
Osteoarthritis	Osteoporosis
Fibromyalgia	other: _____

Please list any surgeries you have had on your feet, legs or back: _____

Have you worn orthotics before? Yes/No If yes, please give details: _____

Are you involved in activities which stress your feet? Please describe the activity and frequency:

_____

How often are you on your feet during the day?
0% – 24% 25% – 49% 50% – 74% 75% – 100%

Pain: What is the location of your pain? _____

On a scale from 1 to 10, where 10 is the worst pain you have ever had, mark where your pain is today:

1 2 3 4 5 6 7 8 9 10
List the shoes you wear most often: _____
Which are the most comfortable? _____
What is your primary concern about your feet? _____
What do you hope to achieve in this visit today? _____