PEDORTHIC ASSESSMENT FORM

NAME:	DOB: (Yr)	(Mth)	(Day)
ADDRESS:		CITY:	
PHONE:	Bus/Cell PHONE:		
EMAIL:			
OCCUPATION:	INSURANCE PROVIDER:		
FAMILY DOCTOR:	REFERRING PROFESSIONAL:		

How did you hear about us? _____

SHOE SIZE: _____ WEIGHT: _____

Fees for Pedorthic services are as follows:

Custom-Made Foot Orthotics are $500 (no HST). A $150 deposit is due upon ordering orthotic devices. Remainder of the payment is required upon delivery/ fitting of your orthotics.

If you are NOT going ahead with orthotics at the time of your initial assessment, please be prepared to pay a $50 (+HST) assessment fee. This fee is waived with the purchase of custom-made foot orthotics and can be applied to later orthotic purchases (within 6-months).

Please note that all extended health care plans are different and therefore subject to different rates of reimbursement. Due to previsions in the Privacy Act, your insurance company cannot disclose your insurance policy information to anyone else on your behalf. Therefore, it is each patient's responsibility to consult their insurance company for the requirements particular to their policy. You will receive a copy of your biomechanical report, supporting paperwork and paid receipt to be submitted along with your prescription to your extended health care insurance company in order to be reimbursed

Follow-up visits and adjustments to your orthotics are at no additional charge for a period of 6-months. Upon consenting to be casted you are giving permission to commence manufacture of your orthotics and understand that you are responsible for the cost. There are no refunds.

We understand the importance of protecting your personal information and follow the guidelines of the Personal Information Protection & Electronic Documents Act. Personal information gathered on these forms and your ongoing file are collected to help access your health and plan your course of treatment.

☐ I give consent to send my family/-referring doctor a report relating to my Pedorthic examination

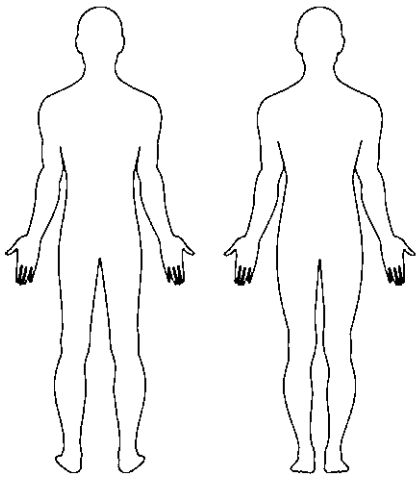
I understand all of the above information and give consent to be treated by Angela Quick C.Ped(C).

Print Name: _____ Date: _____

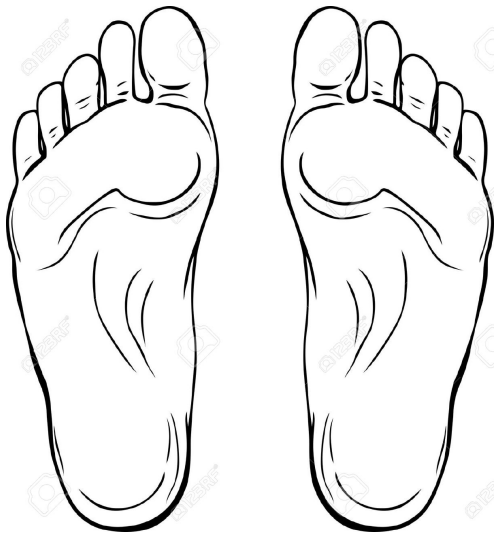
Signature: _____

Parent or Legal Guardian: _____

Please indicate the area(s) of concern on the diagrams below:



(Back) (Front)



(Right) (Left)

Current Complaint: _____ How long have you had the pain? _____

Has this condition occurred before? ☐ YES ☐ NO If "yes" when _____

Is this condition: ☐Job-Related ☐Activity-Related ☐Accident-Related Other: _____

When do you experience pain?

☐Morning ☐Walking/Running ☐Standing ☐Movement ☐Rest ☐Night-time
☐Barefoot ☐Certain Shoes Other:_____

Quality of Pain: ☐Dull ☐Sharp ☐Constant ☐Intermittent ☐Achy ☐Burning ☐Numb

Does the pain limit you? ☐ YES ☐ NO

What is the overall level of pain? (Circle one)

Least 1 2 3 4 5 Worst

Current Treatments:

☐Physiotherapy ☐Chiropractor ☐Massage ☐Ice ☐Heat ☐Stretching ☐Exercises
☐Rest ☐NSAIDS ☐Bracing Other: _____

History of surgery? _____ Date: _____

Have you been diagnosed with any of the following conditions?

☐Osteoarthritis ☐Rheumatoid Arthritis ☐Circulatory Conditions ☐Stroke ☐Diabetes
☐Leg/Foot Fracture ☐Heart Condition Other: _____

Do you experience fatigue or swelling in you legs? ☐ YES ☐ NO

Have you ever worn? ☐Shoe Inserts ☐Orthotics If yes, how old are they? _____

What activities do you participate in? _____

What type of footwear do you wear?

Home:_____ Work: _____ Sports: _____