

## CASE HISTORY for ORTHOTICS

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Workplace: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Referred by: \_\_\_\_\_

Date of Birth (D/M/Y): \_\_\_/\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Children's Names & Ages: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

What is your major complaint presently? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had a similar condition in the past? Yes / No

What activities aggravate your condition? \_\_\_\_\_

What relieves your condition? \_\_\_\_\_

Are you getting pain or numbness in any area:  Arms  Hands  Head  Buttock  Legs  Calf  Foot

Is your condition getting progressively worse?  YES  NO  It's constant  It comes and goes

Pains are:  Sharp  Dull  Burning  Tightness  Throbbing  Other: \_\_\_\_\_

Is this condition interfering with your:  Work  Daily Routine  Other: \_\_\_\_\_

Other doctor(s) who treated this condition: \_\_\_\_\_

List all surgical operations and years: \_\_\_\_\_

Drugs you now take:  Anti-inflammatory  Pain Killers  Muscle relaxants  Blood Pressure  Tranquilizers

Insulin  Birth Control Pills/Injection  Other: \_\_\_\_\_

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports  Orthotics

Have you been in an automobile accident?  None  Past Year  2 to 5 years  Over 5 years

Describe accident: \_\_\_\_\_

Have you had any other personal injury or accident?  None  Past Year  2 to 5 years  Over 5 years

Describe the accident: \_\_\_\_\_

Date of last full physical examination: \_\_\_\_\_

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that River Oaks Chiropractic and Wellness Centre will prepare necessary reports and forms to assist me in making collection from the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

\_\_\_\_\_  
Printed Name of Patient or Parent/Guardian

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date Signed