family chiropractic centre

Dr. Michael Pernfuss D.C
Dr. Greg Goodbrand B. Sc., D.C
Jerzy Sapieha D.Ch

ORTHOTIC PATIENT INTAKE FORM

PERSONAL INFORMATION

DATE:

TITLE: MR.☐ MRS.☐ MISS.☐ MS.☐ MX.☐

FIRST NAME	INITIAL	LAST NAME

ADDRESS	APT #	CITY	PROVINCE	POSTAL CODE

HOME TELEPHONE	EMAIL ADDRESS

BIRTH DATE DAY/MONTH/YEAR	☐ FEMALE ☐ MALE	OCCUPATION

Referred By:

Extended Health Care Insurance Information:

NAME:	Company:	Plan #	ID#
Spouse:			Spouse D.O.B:

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ YES ☐ NO

DOCTOR'S NAME	DOCTOR'S TELEPHONE NUMBER	LAST VISIT

ADDRESS	CITY	PROVINCE	Postal	YOUR: HEIGHT	WEIGHT	SHOE SIZE

DO YOU HAVE ANY ALLERGIES:

MEDICATIONS:

SURGERIES:

MEDICAL HISTORY

Please check "√" if you are experiencing the following symptoms or have in the past.

- ☐ **Low Back**
- ☐ **Osteoarthritis**
- ☐ **Knee**
- ☐ **Arches**
- ☐ **Calluses**
- ☐ **Numbness in feet or legs**
- ☐ **Hip (s)**
- ☐ **Leg(s)**
- ☐ **Foot**
- ☐ **Ankle**
- ☐ **Swelling of ankles**
- ☐ **Varicose veins**
- ☐ **Poor Circulation**
- ☐ **Edema (Swelling)**
- ☐ **Heel**
- ☐ **Bunion**
- ☐ **Rheumatoid**
- ☐ **Other _____**