eastman
THERAPY CENTRE

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ORTHOTIC INTAKE FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code:_____

Date of Birth (DD/MM/YY): _____ Email Address: _____

Phone Number: *Home* _____ *Cell* _____ *Other* _____

Preferred Method of Appointment Reminder *(Circle One)* Phone *or* Email *or* Text

Do you have extended health insurance (benefits)? Yes / No

If "Yes", which company? _____ Policy/ ID Number _____

FEE SCHEDULE AND CONSENT

Fees for Orthotic services are as follows:

Custom-made Foot Orthotics are $350. A $150 deposit is due upon ordering orthotic devices. Remainder of the payment is required upon delivery/fitting of orthotics.

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

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.

Upon consenting you are giving permission to commence manufacture of your orthotics and understand that you are responsible for the cost. There are no refunds as orthotics are custom-made device specific to your measurements and needs.

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

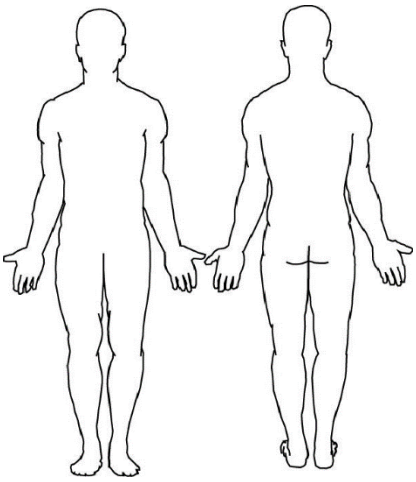
I understand all the above information and give consent to be treated by Dave Blatz.

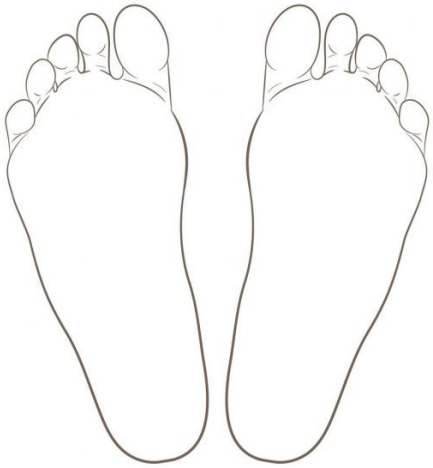
Client Name: _____ Date:_____

Signature: _____

Parent or Legal Guardian: _____

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





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

Has this condition occurred before? Yes *or* No If "yes" when_____

Is this condition *(Circle One):* Job Related Activity-Related Accident Relate 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 *or* No

What is the overall level of pain? *(Circle One)*

Least 1 2 3 4 5 Worst

Current Treatments:

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

History of surgery: _____ Date: _____

Have you been diagnosed with any of the following conditions?

☐Mechanical Low Back Pain ☐Plantar fasciitis ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Circulatory Conditions
☐Stroke ☐Diabetes ☐Leg/Foot Fracture ☐Heart Condition Other: _____

Do you experience fatigue or swelling in your legs? Yes *or* 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: _____