RIVER OAKS CHIROPRACTIC
& WELLNESS CENTRE

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