Footcare Questionnaire

THE GRANDE FAMILY CHIROPRACTIC

#206-168 East 13th St., North Vancouver, BC Tel: 604-990-6676

Date: _____

Last Name: _____ First Name:_____

Address: _____City: _____ Prov: _____ Code: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Birth Date (mm/dd/yyyy)____/____/_____ Sex: F / M Family Doctor: _____ Tel: _____

Occupation: _____ Care Card #: _____ Extended Health Insurer: _____

How did you discover our office? _____

If referred, whom may we thank for referring you to our clinic? _____

Part 1: Your Health Concerns or Symptoms and How They May Affect Your Life

1) Do you have any foot problems such as bunions, corns, flat feet, etc? Please describe the location of your pain/complaint.

_____

_____

2) Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

3) Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No

Where? _____

4) Do you have any numbness or tingling in your body? Yes No

Where? _____

5) Please grade the severity of your pain (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

6) When did this situation or concern begin? _____

7) Why do you think this has happened? _____

8) How frequent is complaint present, how long does it last? _____

9) Does anything aggravate the complaint? _____

10) Does anything make the complaint better? _____

11) Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes No

If yes, what were you told? _____

What was done? _____

Did that seem to work? _____

12) Please grade the level to which your complaint(s) affect these aspects of your functioning and or quality of life.

0 - No effect **1 - Slight effect** **2 - Moderate effect** **3 - Drastic effect**

Effect on work	0 1 2 3	Effect on recreation/play	0 1 2 3	Effect on rest/sleep	0 1 2 3
Effect on social life	0 1 2 3	Effect on walking	0 1 2 3	Effect on sitting	0 1 2 3
Effect on exercise	0 1 2 3	Effect on eating	0 1 2 3	Effect on love life	0 1 2 3

Comments: _____

_____

_____

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Part 2: Health / Trauma / Medical / Chiropractic History

1) Have you had a prior injury to your feet, ankles, knees, hips, or back? Yes No
Please describe: _____

2) Is one of your legs shorter than the other? Yes No
Please describe: _____

3) Do you stand or walk on hard surfaces for more than 4 hours daily? Yes No
Please describe: _____

4) In the past, have you been fitted for custom-made orthotics? Yes No
If so, what kind? _____
What was the reason for wearing them? _____

5) Have you had any spinal X-Rays, CT scans or MRI imaging of your feet or ankles? Yes No
If yes, when: _____
What were you told about them? _____

6) Have you had any surgeries on your feet, ankles, knees, hips, or back? Yes No
Please explain: _____

7) Have you broken any bones, or significantly sprained any part of your lower body? Yes No
Please explain: _____

8) Do your shoe heels wear unevenly? Yes No
Please describe: _____

9) Do your toes point outwards when you walk? Yes No

10) Do you have an exercise program or are you involved in any sports/recreational activity? Yes No
If yes, please describe: _____

11) Have you been diagnosed with Diabetes or Arthritis? Yes No
Please describe: _____

Fee Schedule

Initial Consultation & Examination	$ 50.00
Prescription Orthotics	$ 400.00
Premium / Specialty Prescription Orthotics	$ 450.00
Prescription Orthotic Footwear	$ 480.00
Gait Analysis Report	$ 18.00

Please note that all fees are payable at the time of service and order placement.

Signature: _____

Thank you for choosing the Grande Family Chiropractic.