THE Orthotic Centre
Healthy Foundations for a Healthier You!
Dr. Adrina Patterson D.C.

743 Cataraqui Woods Drive, Unit 1
Kingston, ON
Phone: (613) 389-5331 Fax: (613) 389-7246
E-mail: info@kwfc.ca
www.kwfc.com

NEW PATIENT FORM

Name: _____ Birth Date (M)_____/ (D)_____/ (Y)_____

Address: _____

City: _____Province:_____ Postal Code:_____

Home Phone: _____ Work Phone: _____

Best time to call: _____

E-Mail Address: _____

Workplace:_____ Occupation: _____

Medical Doctor:

Name: _____ Phone: _____

Address: _____

How did you learn about our office?

Patient (Name): _____Newspaper: _____

Internet_____ Phone book_____

Other health care provider (Name and address):_____

Other: _____

PERSONAL HEALTH HISTORY

What is your reason for attending our office today? _____

Your height: _____ Your weight:_____

Approximate shoe size (most commonly worn) _____

Do you currently wear: □ heel lifts □ orthotics □arch supports
If yes, to orthotics, how old are the orthotics? _____ How many pairs do you have? _____ Where were they made? _____

If you are not currently wearing orthotics, have you worn orthotics in the past? □Y □N

Please select what type of footwear that you wear approximately 80% of the time or greater.
□Casual shoes □ Loafers □ Running shoes □ Walking shoes
□Work boots □ Dress shoes □ Heels □ Sandals

In the past, or at present do you have:

□Heel pain	□Ankle sprains/trauma	□Arthritis: foot/ankle/knees/hips/back
□Plantar fasciitis	□Knee pain/trauma	□Headaches
□Metatarsalgia	□Hip pain	□Numbness in toes
□Heel spurs	□Back Pain	□Circulatory disorders
□Achilles tendonitis	□Neck Pain	□Pins and needles in toes
□ Bunions	□Diabetes	□Claw toes
□Forefoot pain	□Hammer toes	□Corns
□ Calluses	□Flat feet	□High arches
□Shin splints	□Patellofemoral syndrome	□Iliotibial band syndrome

Have you had any surgery on your feet/ankles/knees/hips/back? □Y □ N
If yes, please list surgical procedures and dates: _____

_____

If applicable, did you wear high heeled shoes in the past? □Y □ N
If yes, for how many years _____ Hours per day (approximate)____ Heel height _____

What are your occupational demands?

Approximately how many hours a day are spent:

Standing _____ Walking_____ Sitting_____

Sports and Recreation:

What is your level of competition: □recreation □competitive
Hours per week spent on athletic activities □ <3 hours per week □3-6 hours □>6hours

Please list types of athletic activities that your engage in on a regular basis:

If you are a runner, please indicate how often you run _____
the distance run on average _____
type of running shoe worn _____
age of running shoes: _____

Do you have any extended health care coverage for orthotics? □Y □N

Do you require a prescription for your orthotics? □Y □N

Would you like any other information on additional services offered at this practice:

□Y □ N If yes, □Chiropractic □Massage Therapy □Both