Merivale Chiropractic Clinic
460 West Hunt Club Road
Ottawa, ON K2E 0B8

TOG GaitScan™

Our GaitScan™ System is a revolutionary diagnostic tool for assessing your biomechanics. GaitScan™ has an industry high 4096 sensors and scans at an industry high 125Hz. These measurements help us to determine your foot needs. TOG GaitScan™ is the most technologically advanced gait analysis system available.

Patient Introduction

Personal History:

Mr.__ Mrs.__ Miss__ Ms.__ Dr.__

Name: _____
First Middle Last

Your Address: _____

City:_____ Prov:_____ Postal Code:_____

Telephone: Home:_____Bus:_____ Cell:_____

Birth Date: (DD-MM-YYYY) _____-_____-_____ Age:_____Male:____ female:____

Referred to our Centre by: _____

E-Mail: _____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

☐ Would you or your workplace/common interest group benefit from a complimentary workshop on how to improve health and reduce injuries?

To be filled by Doctor:

Shoe Size_____ Weight(lbs)_____ Height (ft)____(In)_____

☐ First orthotic Who recommended orthotics_____

Reason for purchasing the orthotic ☐prevention ☐correction of a problem ☐_____

☐ Foot problem how long _____ (need location, duration, severity, etc._____

_____

Family history of foot problems (parents, children, spouses)_____

_____

What type of shoes will they use the orthotic for_____

Which type of orthotic ☐full ☐¾ length ☐_____

Which regular activities ☐runner, ☐recreational athlete, ☐sedentary ☐_____

☐ Diabetic ☐ Low back pain ☐ Seeing a chiropractor _____

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Our Fee Structure

Please note our fees for your initial visit:

Examination / Gait scan Analysis	$150.00 (includes foam cast if needed)
Insoles	$500
TOTAL	**$ _____**

Should you decide to order the orthotics; the gaitscan and the analysis cost will be included. Please also note that your clinical Report, the time that your doctor will spend with you to go over your results, as well as the 1-month, 6-month, and 12-month fittings are also included.

SIGNATURE: _____ DATE: _____
(Signature of Parent/Guardian required if patient under age 18)

Consent Form

Consent to Physical Examination

I understand that in order to accurately assess my condition a thorough physical exam & gait scan must be conducted which may cause some pain. I consent to having a gait scan that may be performed by the Chiropractor or the Chiropractic Assistants.

I consent to having the physical exam performed on me to fully assess my condition.

Print Name: _____, Date:_____
(Patient Name)

Your Signature: _____
(Patient or Parent/Guardian Signature if patient under age 18)

Witness: _____

☐Dr. Leo Lachowich #1637 ☐Dr. Tatyana Lachowich #5699

Your Informed Consent

I hereby consent to any and all services recommended to me by my Doctor of Chiropractic, including, but not limited to: Arbonne, Metagenics Supplementation, Orthotics, Acupuncture, Posture and Exercise Aids, Chiropractic, Modalities and Neuropathy treatments.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Merivale Chiropractic Clinic. This consent applies to all present and future treatment for myself and my family. I understand that I may remove my consent at any point during my treatment plan.

Payments for gait scan and/or foam cast can be applied to the cost of orthotics within one year of examination. I am aware that any modifications to my orthotics are subject to a charge above and beyond the cost of the initial orthotic. However, removal of component(s) of an orthotic is not subject to a charge as long as it is removed within 60 days of the orthotics being shipped out. Shipping charges apply to removal and additions of orthotic components. I understand that signing this sheet does not contractually obligate me to purchase orthotics.

Print Name: _____, Date:_____
(Patient Name)

Your Signature: _____
(Patient or Parent/Guardian Signature if patient under age 18)

Witness:_____

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Adult Consultation History

Your Name: _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

_____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication?_____, Please list all: _____

_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

_____

Do you have any children? _____# of children: _____

Children's Names:_____

Do they have any health problems that you are aware of? _____

_____

Is there any other information you would like us to know?_____

_____

_____

_____

SIGNATURE: _____ DATE: _____

For Women Only

Date of your last menstrual period: _____Do you suffer from PMS? _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Thank You!