Merivale Chiropractic Clinic
Merivale Mall
1642 Merivale Rd., Unit 360
Ottawa, ON K2G 4A1

PERIPHERAL NEUROPATHY - Patient Introduction

Personal History:

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

First ______________________Middle Ini.________Last______________________

Your Address: ____

City:______________________________ Prov:______________________

Postal Code:______________________

Telephone: Home:______________________ Bus:______________________

Cell:______________________

Birth Date: (DD-MM-YYYY) _____-_____-_____ Age: ________ Male:__________ Female:__________

Occupation: ______________________Employer: ______________________

Marital Status:______________________Spouse's Name:______________________

Previous Chiropractor:______________________City: ______________________

Last visit to this Chiropractor:______________________________________

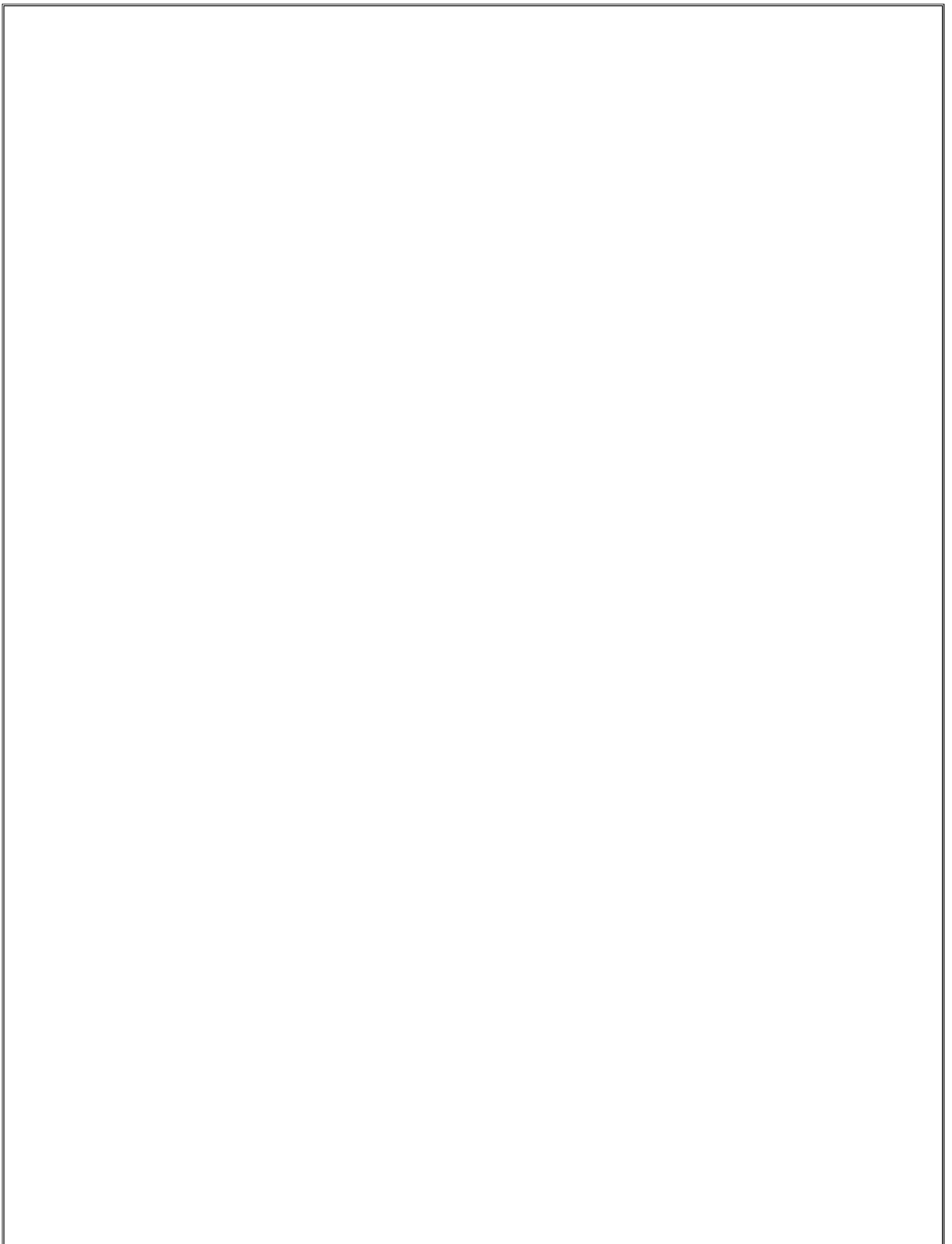
Reason for leaving: ______________________________________

Present MD:______________________City: ______________________

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.



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PERIPHERAL NEUROPATHY - Intensity Questionnaire

Full Name: ________________________________ **Date:**____________________

This questionnaire asks you about the intensity of symptoms in legs, feet & arms you may experience. Please provide answers based upon your experience of the symptoms in legs and feet over the period of the past week only. Thank you for helping.

1. How would you rate the discomfort in your legs, feet & arms?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

2. How would you rate the restlessness in your limbs? (i.e. do you feel you need to keep moving around for relief?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

3. How much relief do you get from moving around?

Legs	Feet	Arms
☐ (4) No relief	☐ (4) No relief	☐ (4) No relief
☐ (3) Mild relief	☐ (3) Mild relief	☐ (3) Mild relief
☐ (2) Moderate relief	☐ (2) Moderate relief	☐ (2) Moderate relief
☐ (1) Either complete or almost complete relief	☐ (1) Either complete or almost complete relief	☐ (1) Either complete or almost complete relief
☐ (0) No RLS symptoms to be relieved	☐ (0) No RLS symptoms to be relieved	☐ (0) No RLS symptoms to be relieved

4. How severe is your sleep disturbance due to your symptoms?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

5. How severe was your tiredness or sleepiness during the day due to your symptoms?

☐ (4) Very severe
☐ (3) Severe
☐ (2) Moderate ☐ (1) Mild ☐ (0) None in the past week

6. How much does your condition impact your quality of life as a whole?

☐ (4) Very severe/ debilitating
☐ (3) Severe
☐ (2) Moderate
☐ (1) Mild
☐ (0) None in the past week

7. How often did you get symptoms?

Legs	Feet	Arms
☐ (4) Very often (6 to 7 days in 1 week)	☐ (4) Very often (6 to 7 days in 1 week)	☐ (4) Very often (6 to 7 days in 1 week)
☐ (3) Often (4 to 5 days in 1 week)	☐ (3) Often (4 to 5 days in 1 week)	☐ (3) Often (4 to 5 days in 1 week)
☐ (2) Sometimes (2 to 3 days in 1 week)	☐ (2) Sometimes (2 to 3 days in 1 week)	☐ (2) Sometimes (2 to 3 days in 1 week)
☐ (1) Occasionally (1 day in 1 week)	☐ (1) Occasionally (1 day in 1 week)	☐ (1) Occasionally (1 day in 1 week)
☐ (0) Never In the past week…	☐ (0) Never In the past week…	☐ (0) Never In the past week…

8. When you experienced symptoms, how severe are they on average?

Legs	Feet	Arms
☐ (4) Very severe (8 hours or more per 24 hour)	☐ (4) Very severe (8 hours or more per 24 hour)	☐ (4) Very severe (8 hours or more per 24 hour)
☐ (3) Severe (3 to 8 hours per 24 hour)	☐ (3) Severe (3 to 8 hours per 24 hour)	☐ (3) Severe (3 to 8 hours per 24 hour)
☐ (2) Moderate (1 to 3 hours per 24 hour)	☐ (2) Moderate (1 to 3 hours per 24 hour)	☐ (2) Moderate (1 to 3 hours per 24 hour)
☐ (1) Mild(less than 1 hour per 24 hour)	☐ (1) Mild(less than 1 hour per 24 hour)	☐ (1) Mild(less than 1 hour per 24 hour)
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

9. Overall, how severe is the impact of your symptoms on your ability to carry out your daily affairs, example carrying out a satisfactory family, home, social, school or work life?

☐ (4) Very severe
☐ (3) Severe
☐ (2) Moderate
☐ (1) Mild
☐ (0) None in the past week

10. How severe is your mood disturbance due to your symptoms; example angry, depressed, sad, anxious or irritable?

☐ (4) Very severe
☐ (3) Severe
☐ (2) Moderate
☐ (1) Mild
☐ (0) None in the past week

Thank you for completing this questionnaire

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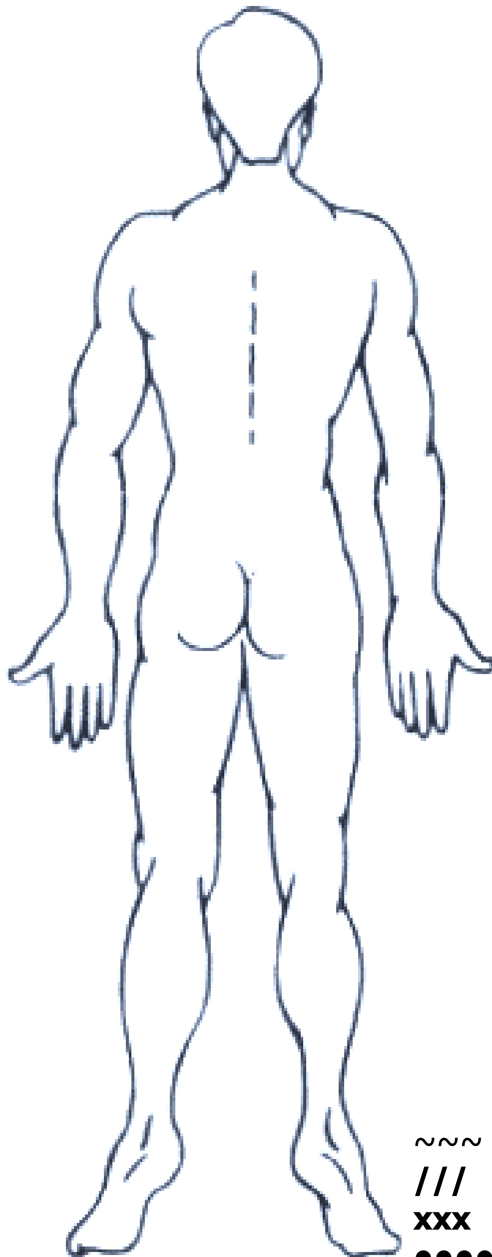
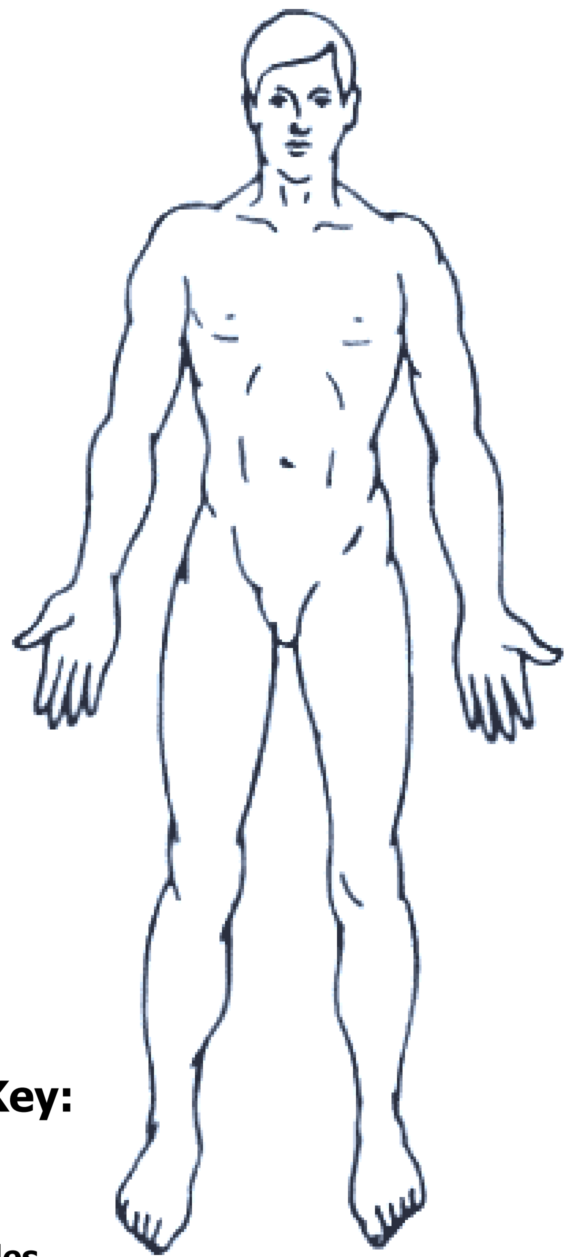
PERIPHERAL NEUROPATHY - Pain Drawing

Patient Name:____

Date:____

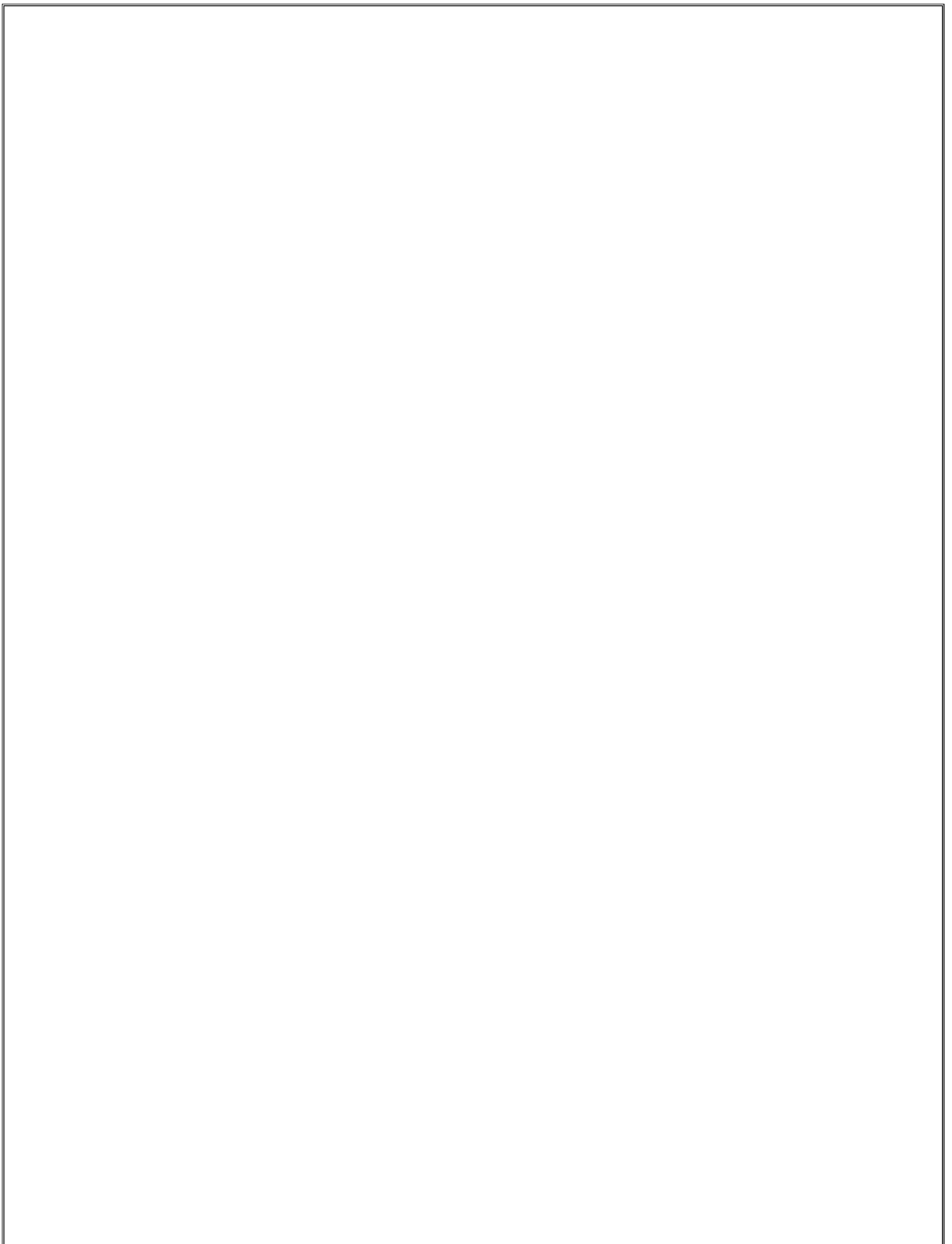
Please describe your current symptoms by marking on the drawing below, using symbols shown in the "Symptom Key", to indicate specific types of sensations.





Symptom Key:

~~	**Dull Ache**
///	**Shooting**
xxx	**Burning**
●●●●	**Pins & Needles**
○○○	**Other**____________________________



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PERIPHERAL NEUROPATHY - Clinic Policies

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

CLINIC HOURS

Our day is divided into office hours, adjustment hours and report hours.

Reports and consultations should be scheduled during report hours only. Adjustment times are as follows:

	Dr. Leo Lachowich	Dr. Tatyana Lachowich
Monday:	3:00pm – 06:45pm	
Tuesday:	7:15am – 11:45am	3:00pm – 06:45pm
Wednesday:	3:00pm – 06:45pm	8:00am – 11:45am
Thursday:		1:30pm – 05:45pm
Friday:	7:15am – 11:45am	7:30am – 11:45am
Saturday:	9:00am – 11:45am	

APPOINTMENT SCHEDULING/MISSED APPOINTMENTS

☐ The Chiropractor has designed a specific course of action to allow proper care, a must for spinal and postural correction. A personal appointment calendar has been designed for you to save time on each visit. If an appointment must be changed, 24 hours notice is required. All missed appointments should be made up later the same day or within 24 hours. Please let our front desk know and changes will be made accordingly.

BROKEN APPOINTMENTS

☐ "No show" appointments are subject to a $150.00 (one hundred and fifty dollar) charge. Please give 24 hours notice so that the doctor may service others in need at your time. If appointments are repeatedly missed, you will regretfully be dismissed from care.

FINANCIAL AGREEMENTS

☐ It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings.

INTERRUPTION OF CARE

☐ In the unlikely event it is necessary to discontinue your care for any reason, any outstanding fees become payable and due immediately to eliminate any misunderstandings.

REMEMBER

☐ Spinal correction and healing take time. If you do not feel satisfied with your body's responses, make an appointment to discuss this with your Chiropractor. We want you to get the most from your care.

KEY FOB

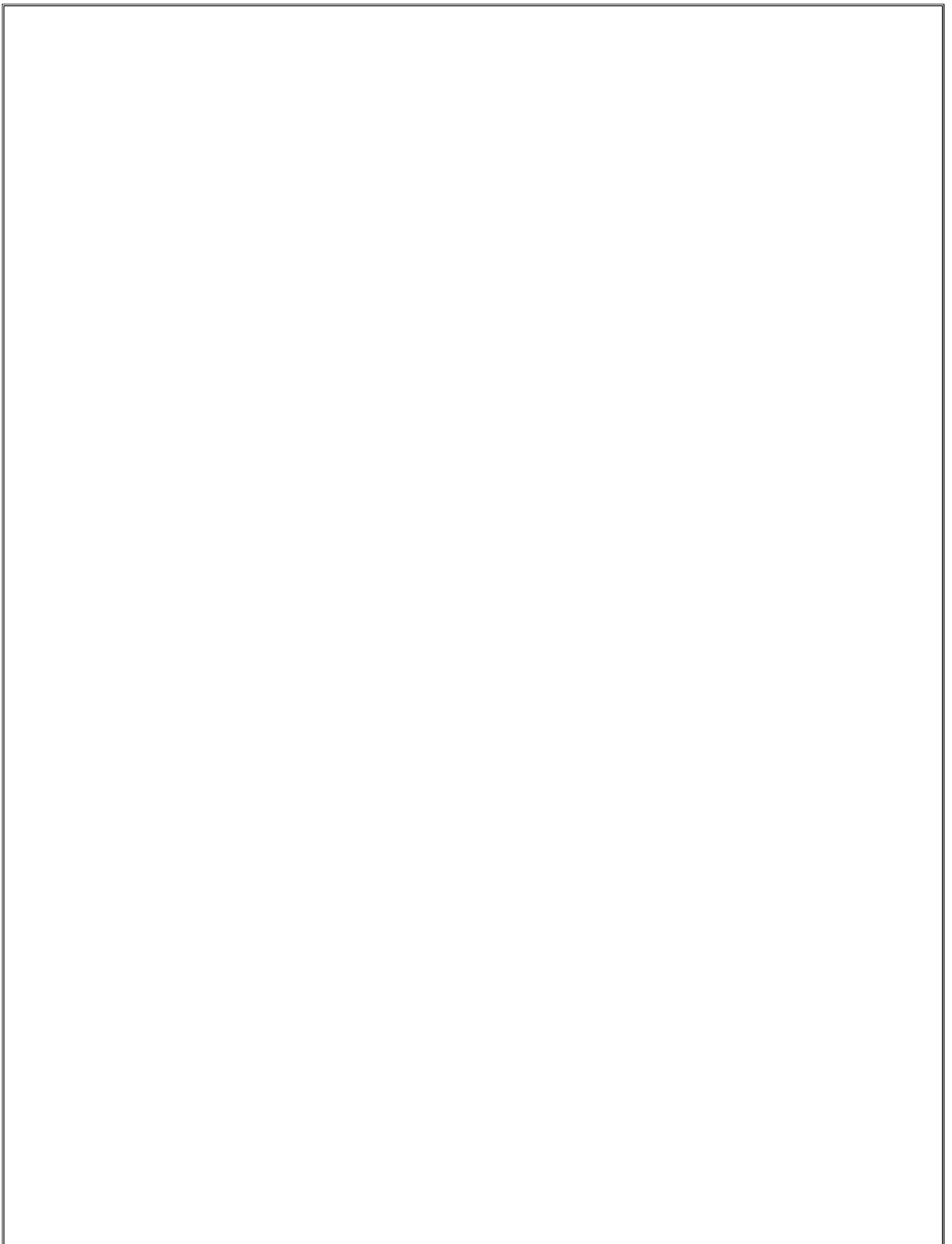
☐ Our clinic uses Key FOB technology for our patients to sign for their appointments. There is a $5.00 deposit for the FOB. The deposit will be returned to you when the Fob is returned to the clinic. If you lose the FOB there will be a $10.00 non-refundable charge for a new one.

SEMINARS

☐ It is highly recommended by your practitioner that you attend our Dinner with the Doc Seminar where the doctor will purchase dinner for you and up to 4 guests. Our patients benefit greatly from the knowledge provided at these seminars.

Signed ______________________________ **Date:**__________________

I have read and understand the above policies and agree to abide by them.



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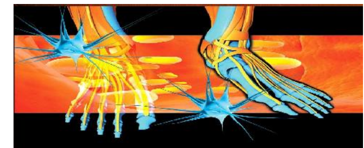


PERIPHERAL NEUROPATHY – Informed Consent

Consent to Physical Examination

I understand that in order to accurately assess my condition a thorough physical exam must be conducted which may cause some pain.

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

Print Name: ________________________________, Date:____

Your Signature: ____

Witness: ____

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

Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

1. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
2. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
3. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.
4. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.
5. Peripheral Neuropathy treatments have been successful. However they are still considered experimental treatments.
6. "Healthlight" system has been known to cause burns.

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

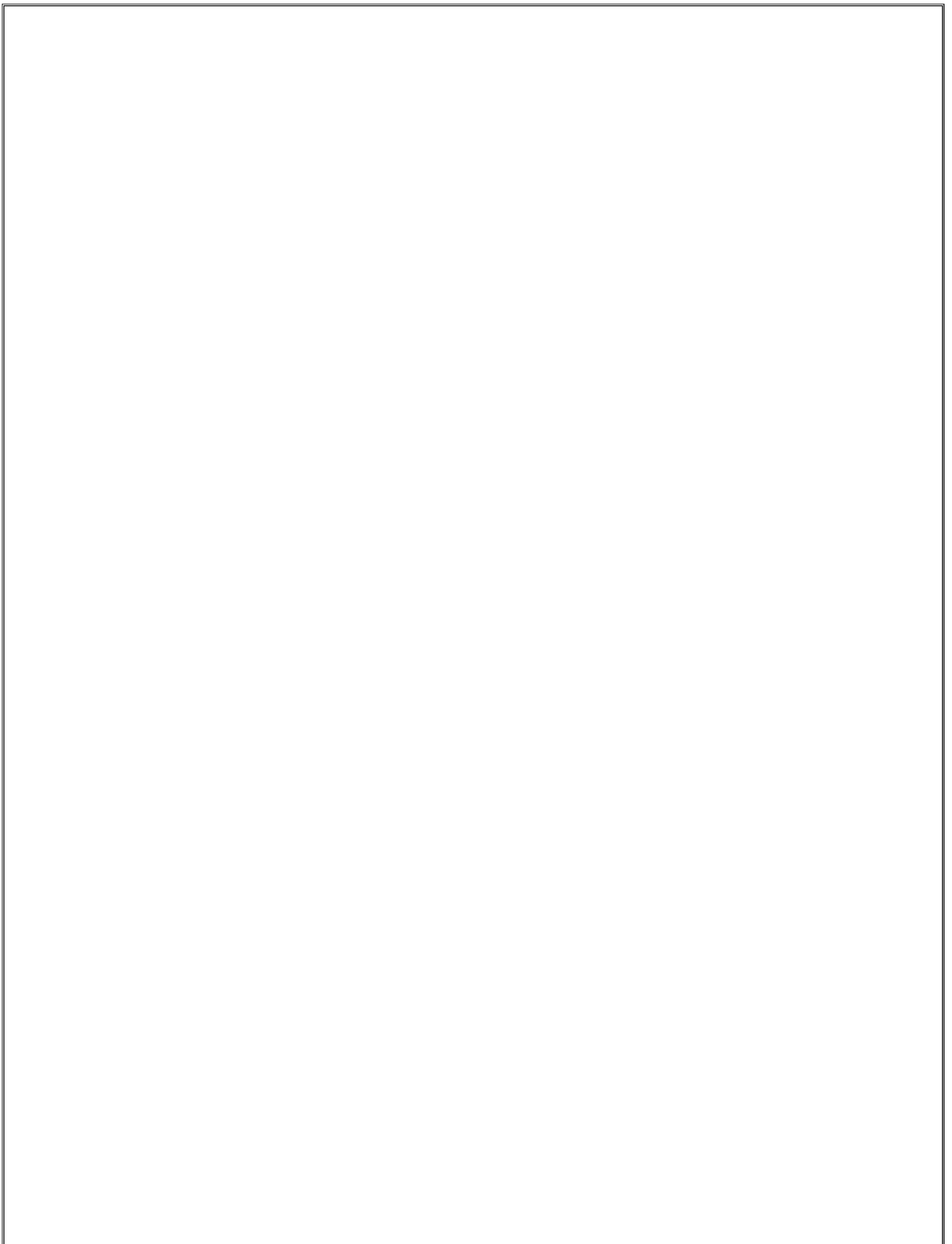
I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Merivale Chiropractic Clinic. This consent applies to all present and future care for my family and me.

I am aware that my practitioner has been specially trained to provide Neuropathy Treatment by "Concentro Laboratories". This treatment does not fall under the general scope of chiropractic care / therapy supported by the college of Chiropractors of Ontario. Should I be receiving or chose to receive chiropractic care at this clinic in the future, I am aware that Neuropathy Treatment (adjustment non-inclusive) is a separate entity from chiropractic care.

Print Name: ____, Date:_______________________________

Your Signature: ____

Witness: ____



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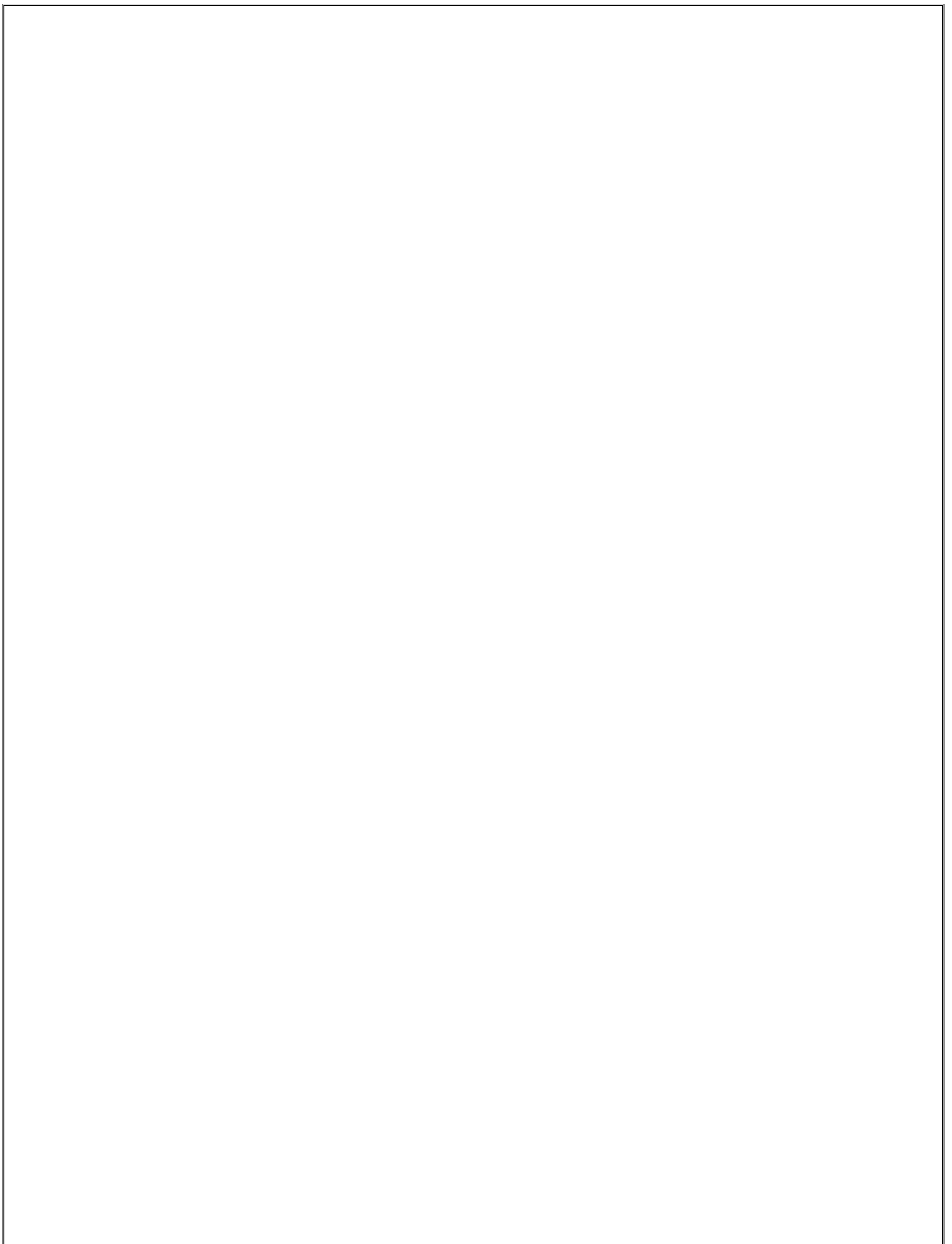
PERIPHERAL NEUROPATHY – Fee Schedule

	Code	Name	Cost
		Neuropathy Protocol	
	4	Consultation	$0.00
One time Fee	44	Neuropathy Initial Exam	$150.00
Per Visit	NHB	Healthlight Boot Rx	$140.00
Per Visit	NWBV	Whole Body Vibration Rx	$20.00
Per Visit	NNR	Nerve Rebuilder Rx	$140.00
Per Visit	NE1	Distal Extremity Adjusting	$12.00
Weekly up to five visits	NMT	Myofascial Release (massage)	$47.25
One time Fee	NRT	Rehabilitative Training Session	$60.00
Every seventh visit	NPE	Re-evaluations	$55.00
		Home Equipment	
If required	STICK	The Stick	$49.00
If required		**Nutritional support**	
	I360	UltraInflammex	$92.00
	UCP	UltraClear	$95.00
	MCLR	MetClear	$59.00
	NEU60	NeuRemedy – 60 Tabs	$36.00
	NEU120	NeuRemedy – 120 Tabs	$65.00
		Chiropractic	
One time fee	3	Chiropractic Exam	$150.00
Per Visit	ADJ	Adjustment	$50.00
If Required	X025B-X705	X-rays	$0-$84
If required	XRR	X-ray Reading / Report	$30.00
If required	MOD/TRA	Modality / Traction	$25.00
		Orthotics	
If required	GS	Gait Scan & Foam Cast	$150.00
If required	-	Orthotic Insoles	$450.00

Signature:______________________________ Date:___________________
(Signature of Parent/Guardian required is patient under age 18)



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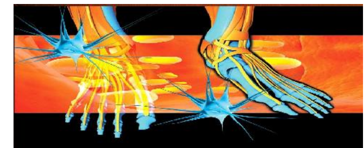


PERIPHERAL NEUROPATHY - Clinical Scoring

Toronto Clinical Scoring System / QST Exam of Lower Leg

Full Name: ______________________________ **Date:**______________________

Control Test = Face, Hand, Fingers, (10=normal) VS Lateral Calf, Foot, Toes

The exam is a "qualitative' comparison of sensations from a non-effected area to one suspected area of sensory loss. The Control area would be considered a "10" and the tested area score is given as a Percentage or Number Value.

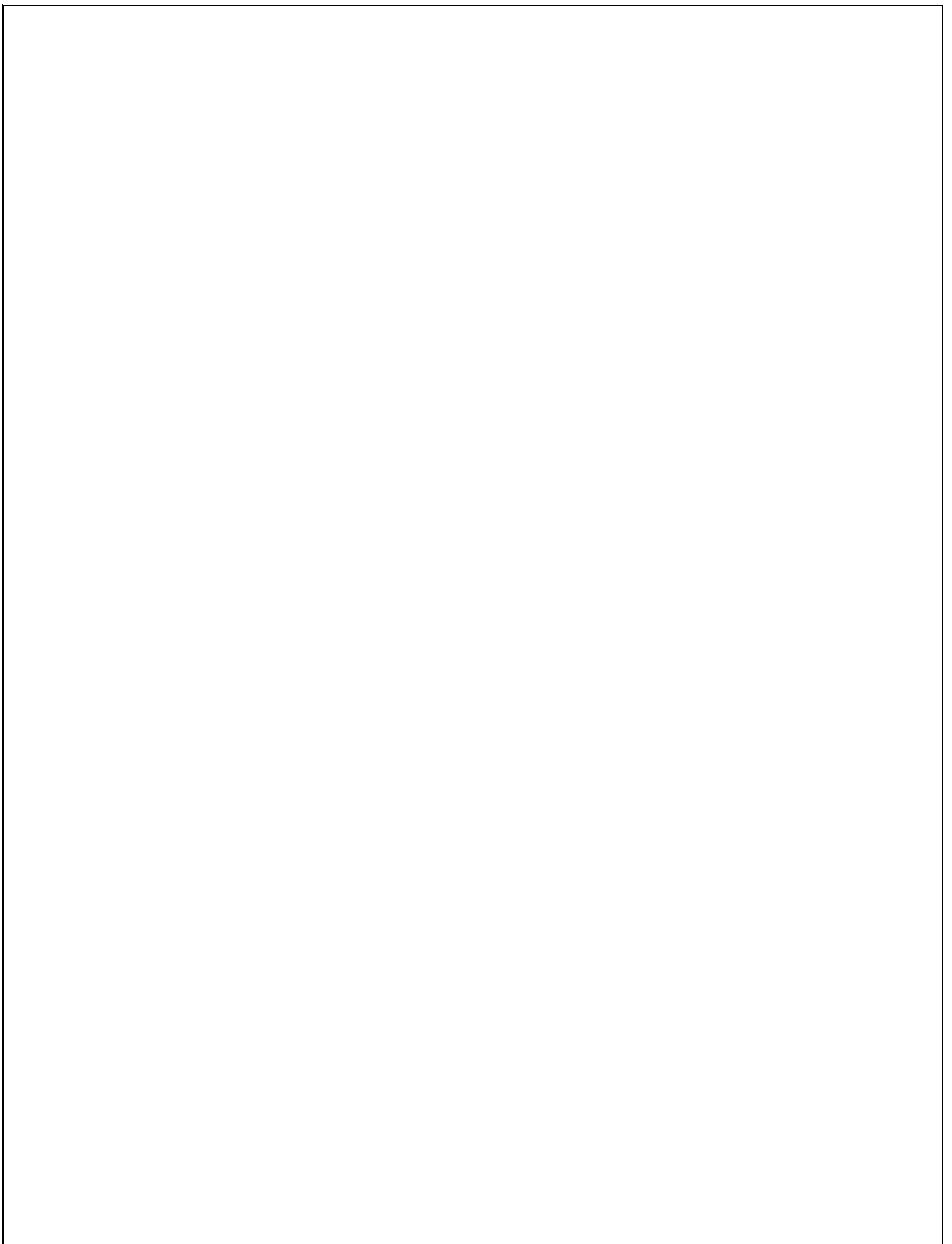
A score of "-5" designates an area of increased sensation.

RIGHT LEG		LEFT LEG
0 1 2 3 4 5 6 7 8 9 10 -5	**COOL**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**VIBRATE**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**COLD**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**WHEEL**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**PRICK**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**HEAT**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2 3 4 5 6 7 8 9 10 -5	**LIGHT**	0 1 2 3 4 5 6 7 8 9 10 -5
0 1 2	**Patellar**	0 1 2
0 1 2	**Achilles**	0 1 2
	TOTAL SCORE	

74 = normal per leg

Cool = the metal of Tuning Fork
Vibration = VPT 128 Hz tuning fork
Cold = Corner of Ice Pack
Wheel = Pinwheel
Heat = Air from Blow Dryer
Pin = MEDIPIN
Light Touch = 10 gm Semmes-Weinstein Monofilament

Validation of the Toronto Clinical Scoring System for diabetic polyneuropathy. Diabetes Care. Bril V, Perkins BA. 2002 Nov;25(11):2048-52.



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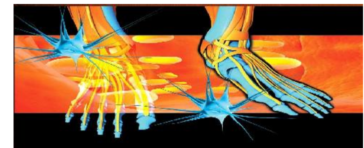


File Number:___________ **Date:**__________________

PERIPHERAL NEUROPATHY - X-Ray REPORT

Patient Name: ____ **Sex:** ☐ Male ☐ Female

Date of Birth: ______________________________ **Date of Study:**___________________________

Clinical Purpose: ____
(Reason for Study)

Films taken: ☐ Cervical AP/LAT ☐ Lumbar AP/LAT ☐ Thoracic AP/LAT
☐ Pelvis AP/LAT ☐ Shoulder
☐ Others (Describe) ____

FINDINGS (Check only appropriate boxes)

Bone Density: ☐ Reduced ☐ Adequate

Lordosis: Cervical Lordosis ☐ Reduced ☐ Normal
with ☐ Anterior ☐ Posterior Shift of the Gravitational Line

Lumbar Lordosis ☐ Reduced ☐ Normal ☐ Increased

Lumbosacral angle: ☐ Reduced ☐ Normal ☐ Increased
with ☐ Anterior ☐ Posterior Shift of the Gravitational Line

Disc spaces: ☐ well preserved

	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12	L1	L2	L3	L4	L5	S	S1	CX
Mild																											
Moderate																											
Severe																											

Scoliosis: Lumbar scoliosis is noted with a concavity to the ☐ Right ☐ Left from Level_________
Thoracic scoliosis is noted with a concavity to the ☐ Right ☐ Left from Level_________
Cervical scoliosis is noted with a concavity to the ☐ Right ☐ Left from Level_________

Rotation/Flexion: Rotation is noted at____
Lateral flexion is noted at____

Soft Tissue: ☐ **Unremarkable** ☐ ____

Also:____
____

IMPRESSIONS ____
____
____

RECOMMENDATION____
____

Dr. Signature____

Merivale Chiropractic Clinic
Merivale Mall

Doctor Name:___________________ Patient Name: __________________ Date:________

FINDINGS

History of Chief Complaint:

Symptoms of Stress

- ☐ H/A, Dizziness,
- ☐ Pins & Needles,
- ☐ Ringing in Ears,
- ☐ Blurring of Vision,
- ☐ Insomnia,
- ☐ Loss of Concentration,
- ☐ Memory Loss,
- ☐ Irritability,
- ☐ Depression,
- ☐ Crying Spells,
- ☐ Decreased Energy

Secondary Complaint:

Surgeries:

Medication:

Accidents:

Family:

Cervical Motion Studies:

	Nor	Exam	Pain
Flexion	60		
Extension	50		
L. Rotation	80		
R. Rotation	80		
L. Lat. Flex	40		
R. Lat. Flex	40		

Dorso-Lumbar Motion Studies

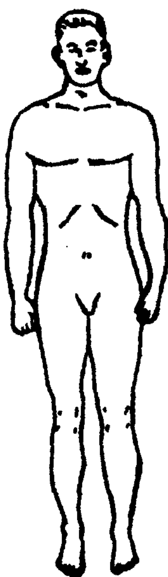
	Nor	Exam	Pain
Flexion	60		
Extension	50		
L. Rotation	80		
R. Rotation	80		
L. Lat. Flex	40		
R. Lat. Flex	40		

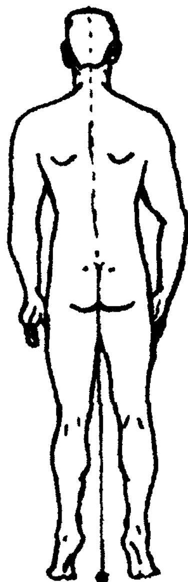
Orthopedic:

	L	R
SLR		
Braggarts		
MHR		
Soto Hall		
Faber Patrick		
Thomas		
Spinous Challenge		

	L	R
Malignes		
Kemps		
C. Kemps		
Doorbells		
Adsons		
Wrights		
Edens		

Posture:



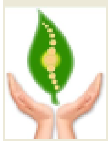


Neurological:

Upper Limb	Lower Limb	Cranial
S	S	
M		
R	R	
Babinski		

Muscle Testing: Dynanometer L R

Visceral, Vascular, Etc.:



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PERIPHERAL NEUROPATHY – Care Plan

Patient Name:________________________ **File Number:** ______________ **Date:**__________________

Doctors fill-in Sheet

QTY	Payment Frequency	Code	Name	Cost
			Neuropathy Protocol	
		4	Consultation	$0.00
	One time Fee	44	Neuropathy Initial Exam	$150.00
	Per Visit	NHB	Healthlight Boot Rx	$140.00
	Per Visit	NWBV	Whole Body Vibration Rx	$20.00
	Per Visit	NNR	Nerve Rebuilder Rx	$140.00
	Per Visit	NE1	Distal Extremity Adjusting	$12.00
	Weekly up to five visits	NMT	Myofascial Release (massage)	$47.25
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	Every seventh visit	NPE	Re-evaluations	$55.00
	If required		**Home Equipment**	
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	If required		**Nutritional support**	
		I360	UltraInflammex	$92.00
		UCP	UltraClear	$95.00
		MCLR	MetClear	$59.00
		NEU60	NeuRemedy – 60 Tabs	$36.00
		NEU120	NeuRemedy – 120 Tabs	$65.00
			Chiropractic	
	One time fee	3	Chiropractic Exam	$150.00
	Per Visit	ADJ	Adjustment	$50.00
	If Required	X025B-X705	X-rays	$0-$84
	If required	XRR	X-ray Reading / Report	$30.00
	If required	MOD/TRA	Modality / Traction	$25.00
			Orthotics	
	If required	GS	Gait Scan & Foam Cast	$150.00
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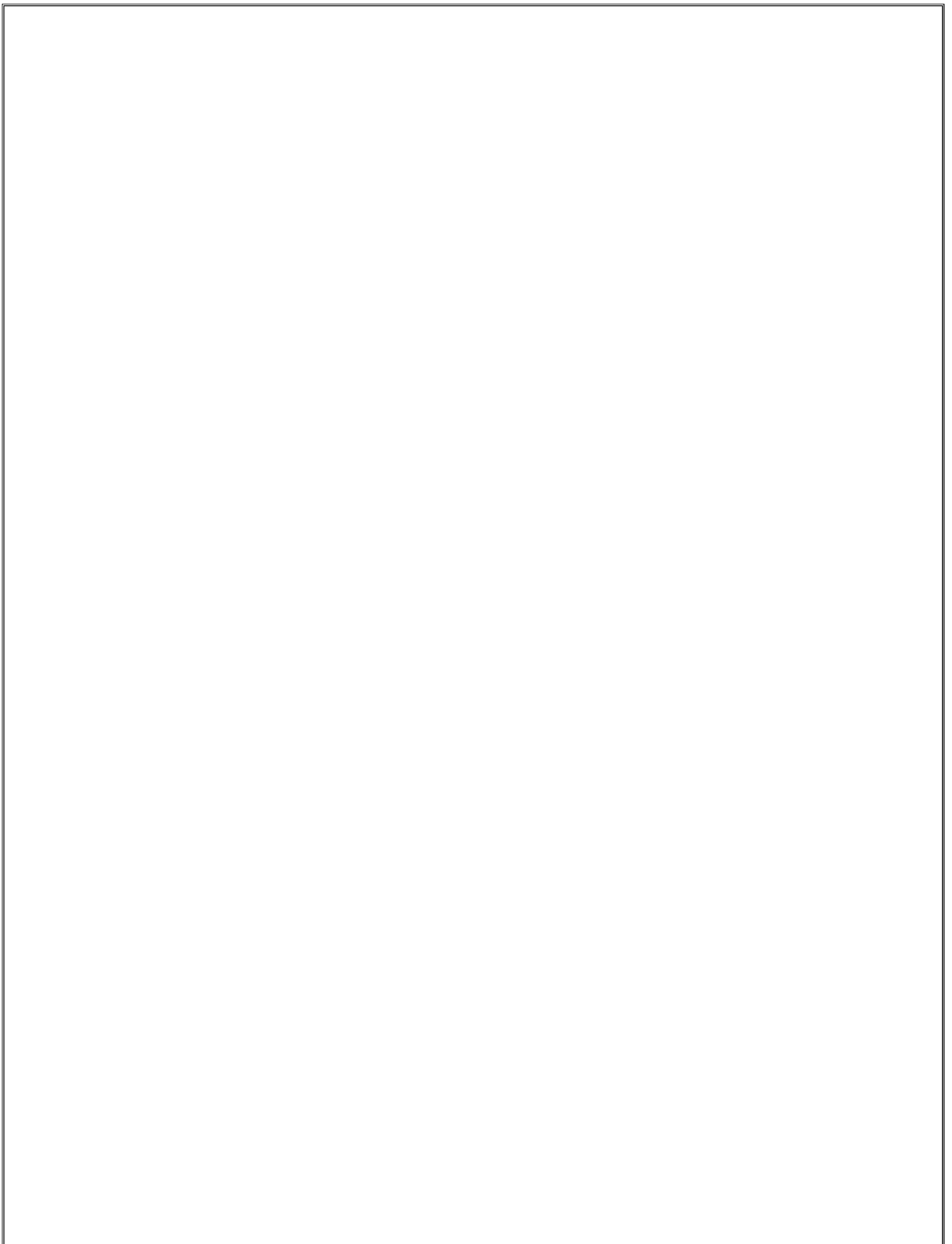

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PERIPHERAL NEUROPATHY
Tips To Help Your Healing…Naturally

1. STANDING

- ✓ Ears should be directly above your shoulders.
- ✓ Shoulders should be back and ***NOT*** slouched forward.
- ✓ Hips should be over the ankles.
- ✓ Walk with your head up or slightly elevated, ***DO NOT*** walk with your head down.

2. SITTING

- ✓ Posture should be upright, not slouched
- ✓ Chair should have adequate firmness to hold your weight. Avoid overstuffed chairs.

3. SLEEPING

- ✓ ***Never*** sleep on your stomach
- ✓ If you sleep on your back, place a pillow under your knees to remove stress on your low back
- ✓ Sleep on your side with a pillow between your knees. It allows your spine to remain in a neutral position.
- ✓ Invest in a high quality mattress.
- ✓ Only use one pillow, preferably a cervical pillow that will support your head and neck so that your neck will be level with the rest of your spine.
- ✓ When you get up from a lying position keep the torso straight, lay down on either side, bringing the feet up, knees and ankles together. Use the arms to help the upper body.

4. DRIVING

- ✓ Sit on the edge of the seat when getting in, swing both legs together, pivoting on an axis.
- ✓ ***Do not*** put one leg in first then sit down heavily.
- ✓ Use a lumbar support to maintain the proper curve in the low back.
- ✓ ***Do not*** sit too far away from the steering wheel. Your arms should feel comfortable and your shoulders back.
- ✓ Stop and take breaks when driving long distances.
- ✓ Your headrest should be adjusted to the proper position. The top of your head should be level with the top of your headrest and your head should be no more than 3 inches in front of the headrest.

5. AT WORK

- ✓ Head up over shoulders
- ✓ Back straight and low back supported with lumbar support.
- ✓ Eyes level with the top of monitor.
- ✓ Hands and wrists relaxed and elbows resting at the side.
- ✓ Thighs and forearms perpendicular to the floor.
- ✓ Feet resting on the floor.
- ✓ Monitor 18-30 inches away and directly in front
- ✓ ***Take regular breaks***. 5 minutes for every hour of sitting.
- ✓ Switch hands when using the phone.
- ✓ ***Do not*** cradle the phone in the crook of your neck.
- ✓ If you use the phone a great deal, consider purchasing a lightweight headset.

6. LIFTING

- ✓ Bend at the knees so you can keep your back straight.
- ✓ ***Never*** bend or twist when lifting.
- ✓ Avoid Quick, jerking movements.
- ✓ Keep the load close to your body.
- ✓ Place heavier loads somewhere they will be easy to pick up.
- ✓ If it is too heavy get help.
- ✓ ***Think before you lift!*** Many injuries occur when people get careless with everyday loads (groceries, children). Make it a habit to lift properly everyday.

7. STRESS MANAGEMENT

- ✓ Set aside a special time each day for complete mental and physical relaxation. This is vital in the restoration and maintenance of normal health.
- ✓ Get plenty of sleep to allow your body to recuperate and repair.
- ✓ Reflect on what you enjoy doing and make sure you set aside time to participate in those activities.
- ✓ ***Remain positive.*** Your body has an amazing ability to heal itself you just have to give it time.

8. EXERCISES

- ✓ ***The Stick- Toothbrush for Muscles***
- ✓ Accelerates muscle recovery.
- ✓ Rapidly prepared muscles for physical activity.
- ✓ Improves strength, flexibility & endurance.
- ✓ Essential in continuing stimulation of nervous system in between the office treatments.
- ✓ Specific exercise will be demonstrated depending on individual needs.

PERIPHERAL NEUROPATHY - *TOG GaitScan™*

Custom Orthopaedic Shoes / Insoles

MCC Insurance Info for Insurance Receipt

Name: ____**Referred By:**________________________________

Custom orthopaedic ☐shoes/ ☐insoles have been prescribed for the above-mentioned patient insured by your company. These custom orthotics have been prescribed in response to the following symptoms, gait analysis and biomechanical evaluation.

SYMPTOMS: Improper foot function and weight distribution of the lower extremities is often the cause of many lower leg, pelvic and back and neck overuse injuries. In this specific case, the problems can be diagnosed as:

- ☐ Abnormal gait
- ☐ Achilles tendonitis
- ☐ Anterior tibialis/shin splints
- ☐ Bunions
- ☐ Diabetic neuropathy
- ☐ Different size feet
- ☐ Heel spurs
- ☐ I -T band syndrome
- ☐ Leg length difference
- ☐ Lower back pain
- ☐ Metatarsalgia
- ☐ Midtarsal collapse
- ☐ MTP collapse
- ☐ Osteoarthritis
- ☐ Patellar femoral syndrome
- ☐ Plantar fasciitis
- ☐ Peroneus tendonitis
- ☐ Severe hallux valgus
- ☐ Severe hammer toes
- ☐ Sacroiliac joint inflammation

Other:____

GAIT ANALYSIS AND BIOMECHANICAL EVALUATION:

Our examination reveals the following imbalances to be contributing to the above problems:

☐ Subtalar overpronation ☐ R ☐ L ☐ Supination ☐ forefoot ☐ whole foot
☐ Functional genu valgus ☐ R ☐ L ☐ Functional genu varus ☐ R ☐ L

Other____

____

Date Biomechanical exam performed: ____

Date Orthopaedic shoe / Insoles dispensed: ____

Casting technique: Non-weight bearing subtalar neutral cast
Technique used to create/manufacture orthotics: Laser scanned negative cast to create corrected positive; then plastic vacuum formed over positive.

☐***Raw materials used – Insoles :*** Engineered copolymer with complete intrinsic memory and predictability postings made from extra firm nickel plast (58-65 Durometers).

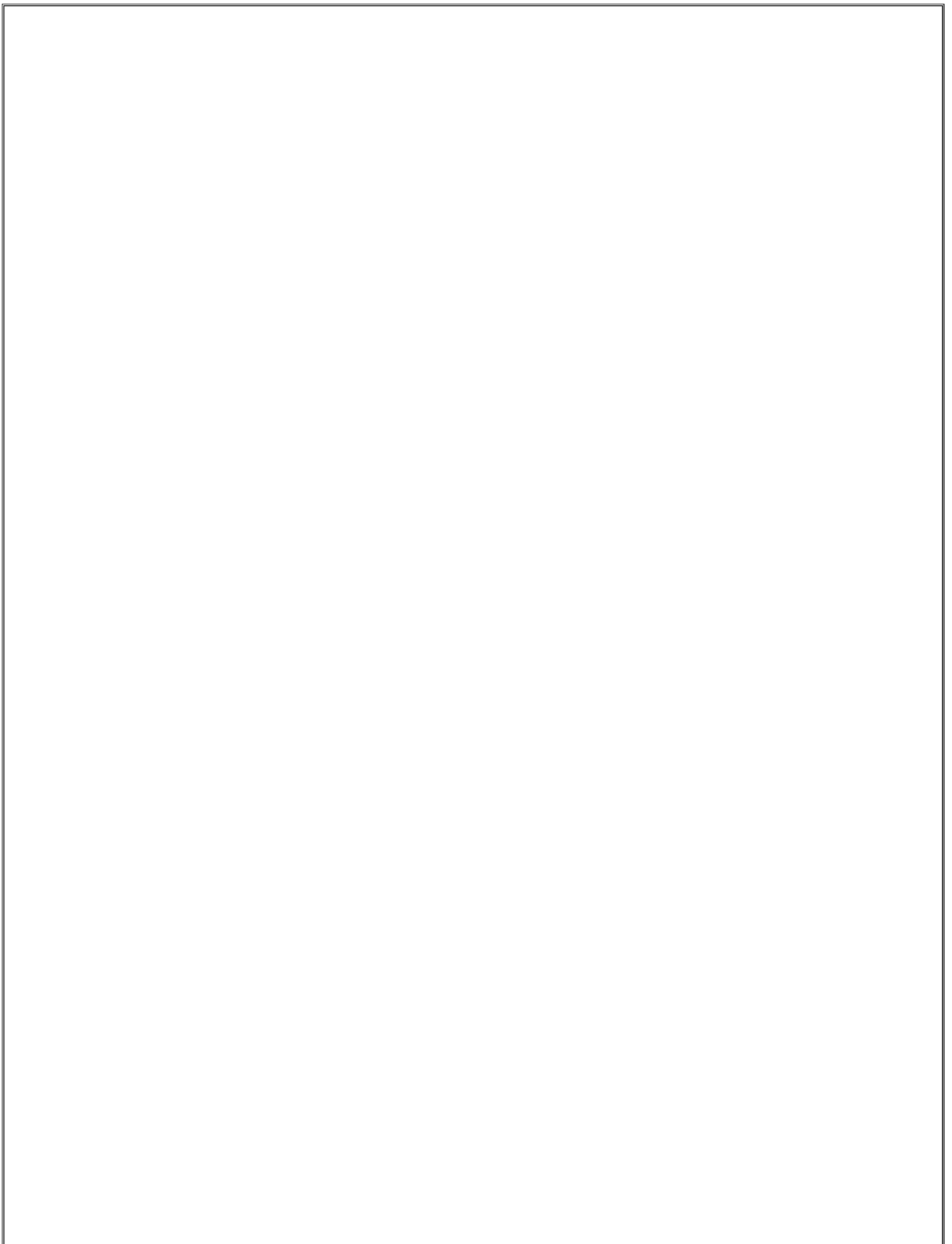
☐***Qualities of Shoe:*** The shoes have a firm heel counter, extra depth heel, extra wide toe box, extra deep toe box, adjustable lacing, custom sole molded to fit patients neutral cast.

LABORATORY INFORMATION AND CREDENTIALS:

Laboratory: The Orthotic Group Inc., Manufacturing podiatry type custom orthotics since 1985. #6-3115 14th Ave., Markham, ON L3R 0H1 (905) 477-8511.
Podiatrist on Staff at The Orthotic Group: Dr. Alan Lustig, D.P.M (Chief Medical Director of The Orthotic Group)

Prognosis: The gait analogies and existing foot problems can be managed and corrected by the devices while wearing them but will not perform a structural reformation of the foot while not wearing the devices. The custom orthopaedic shoes are a medical necessity and must be worn on a day-to-day basis, for an indefinite period of time. Wearing the shoes will alleviate the symptoms caused in the foot, hip and low back. The shoes and the feet and gait should be monitored to watch for change in prescription or breakdown of the device.

The fee for these custom orthopaedic ☐shoes / ☐insoles is ___________ and has been paid in full by the insured.
No part of this fee would be covered by OHIP.



Merivale Chiropractic Clinic
Merivale Mall
1642 Merivale Rd., Unit 360
Ottawa, ON   K2G 4A1

PERIPHERAL NEUROPATHY
The Patient-Specific Functional Scale

Full Name: ________________________________ **Date:**_________________________

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopedic condition.

Clinician to read and fill in below:
Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _________________ or problem. Today, are there any activities that you are unable to do or having difficulty with because of your ______________________ problem?

(Clinician: show scale to patient and have the patient rate each activity).

[Follow-up Assessments:]

When I assessed you on *(state previous assessment date),* you told me that you had difficulty with *(read all activities from list at a time).*

Today, do you still have difficulty with: *(read and have patient score each item in the list)?*

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Able to perform activity at the before problem or injury

Total score = sum of the activity scores/number of activities ***(Date and Score)***

ACTIVITY	**INITIAL**			

Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263. Reproduced with the permission of the authors.