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

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.

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/Shoes	$450 / $500
Shoes	$225
TOTAL	**$ ________________**

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 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:____________________________________

Your Signature: ____

Witness: ____

☐Dr. Leo Lachowich #1637 ☐Dr. Tatyana Lachowich #5699 ☐Dr. Andrew Bell #6223 ☐Dr. Courteney Werner #6909

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.

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 orthotics is not subject to a charge as long as it is removed within 90 days of the orthotics gait scan. Shipping charges apply to removal and additions of orthotic components.

Print Name: ________________________________, Date:____________________________________

Your Signature: ____

Witness:____

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TOG GaitScan™

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: ________________________________

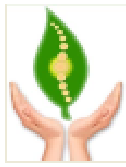
For Women Only

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!



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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. For an appointment time schedule see our website or the front desk staff.

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. It is recommended that all missed appointments be made up later the same day or within 24 hours. Let our front desk know and changes will be made accordingly. Should you be accepted for care, you will have the choice of Relief or Wellness care and your appointments will be scheduled on your Report of Findings visit for the duration of the frequency prescribed by your Doctor of Chiropractic.

PROGRESS EXAMS

☐ In order to comply with the College of Chiropractors of Ontario, progress exams will be provided for you at the cost of **$45.00 (Forty Dollars)** every 12th visit.

BROKEN APPOINTMENTS

☐ **"No show" appointments are subject to a $50.00 (Fifty Dollars) charge**. Please give 24 hours notice so that the doctor may service others in need at your time. If appointments are repeatedly missed we will, regretfully, dismiss you from care.

CHILDREN/FAMILY

☐ Once you understand that the nervous system controls and coordinates all functions of the body and subluxation interferes with nerve flow, we expect that you would want everyone in your family checked. We have cost-effective family programs, and extend the opportunity to have your family checked for only **$47.00 (Forty-seven Dollars)** within 7 days of starting 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, inform us immediately to eliminate any misunderstandings.

INTERRUPTION OF CARE

☐ In the unlikely event it is necessary to discontinue your care for any reason, 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 or are experiencing something other than your expectations, please book a complimentary consultation with your Chiropractor. Your satisfaction with care is important to us and we want to help you reach your health goals.

MODALITIES

☐ Patients receiving modality or traction table treatment are charged **$25.00 (Twenty-five Dollars)** in addition to regular visit fees.

WSIB/ MVA ONLY

☐ I am fully aware that I am responsible for any balances on the account, in the event that your insurance does not approve the treatment plan given by the Doctor.

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.