



# Footnotes

By Dan Brice B.Sc., Kin. A.T., Kinesiologist/Director

**The GAITWAY has two convenient locations:** • 93 Dalhurst Way NW, Calgary, AB T3A 1P1  
• 11636 Sarcee Trail NW, Calgary, AB T3R 0A1

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
City/Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about the Gaitway? Who may I thank for the referral?  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birthday (M/D/Y): \_\_\_\_\_ Foot Size: \_\_\_\_\_

1) For the following **body** areas, please indicate your main health concern.  
**Heel**  R  L **Toes**  R  L **Arch**  R  L  
**Knee**  R  L **Hip**  R  L **Low Back**  R  L  
**Your specific concerns:** \_\_\_\_\_

2) Outline your leisure / work activities, sports and pursuits.  
\_\_\_\_\_

3) Please indicate any Conditions that you have/aware of: **Calluses**  **Corns**  **Bunions**   
**Heel spurs**  **Neuroma**  **Shin Splints**  **Plantar Fasciitis**  **Sciatica**  **IT Band**

4) Do you have: **Diabetes**  **Rheumatoid Arthritis**  **Osteoarthritis**

5) Additional History: \_\_\_\_\_  
\_\_\_\_\_

• What are your expectations for your appointment. \_\_\_\_\_

• Do you/spouse carry Insurance coverage for Orthotics? \_\_\_\_\_ Amt/% \_\_\_\_\_  
Plan/Group # \_\_\_\_\_ I.D. \_\_\_\_\_

**The Gaitway requires A Medical Doctor's or Chiropractor's Prescription to submit to your Insurance carrier.**

*“Your feet are the foundation of your body.”*