Orthotic Patient Information Form

Name: _____ **Date: _____**

Address: _____
(street number/name) (city) (prov) (postal code)

Home Phone#: _____ **Work Phone#: _____**
Cell Phone#: _____
Email address: _____

Referred to us by? :_____ **Marital Status: S/M/CL/W/D**

Occupation: _____

Birthdate: _____ Foot Size:_____ Height:_____ Weight: _____
day/month/year

	Y	N
Do you have diabetes?	☐	☐
Do you have arthritis?	☐	☐

Have you had surgery to your__?	Y	N
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot	☐	☐

Pain Area	Y	N
Heel	☐	☐
Arch	☐	☐
Toe	☐	☐
Ankle	☐	☐
Leg	☐	☐
Hip	☐	☐
Knee	☐	☐
Low Back	☐	☐

Recreational Activities	Y	N
Running	☐	☐
Walking	☐	☐
Dancing	☐	☐
Sports	☐	☐

Other? Please list:
_____
_____
_____
_____
_____

Can you walk a kilometer comfortably? **Y/N**

Can you run, walk, or do another related activity comfortably? **Y/N**

Are your legs or feet tired at the end of the day? **Y/N**

Do you wear or have worn orthotics? **Y/N**