Patient Questionnaire Form

Patient's Name_____Weight_____Height_____Male or Female

1. Have you worn an Orthotic Device (brace) before? Yes or No
   a. If yes, when? _____
2. Have your worn a Prosthetic (artificial limb) Device before? Yes or No
   a. If yes, when? _____
3. Have you worn a Diabetic Shoes before? Yes or No
   a. If yes, when? _____
4. Have your worn Shoe Inserts before? Yes or No
   a. If yes, when? _____
5. Have you worn Custom Molded Foot Orthotics before? Yes or No
   a. If so, when? _____
6. Are you a Diabetic? Yes or No
   a. If yes, are you insulin dependent? Yes or No
7. Are you on Dialysis? Yes or No
8. **Who is your Primary Care Doctor?** _____
9. List any Physicians/Specialists who are currently treating you
   _____
   _____
10. List any surgeries that you have had in the last 5 years, what type of surgery, the year of your surgery, and the surgeon who performed your surgery?
    _____
    _____
    _____
11. Do you have any Foot Pain? Yes or No
    a. Left or Right or Both
12. Do you have any Leg Pain? Yes or No
    a. Left or Right or Both
13. Do you have any Weakness of the legs? Yes or No

a. Left or Right or Both

14. Do you have any Weakness of the ankles? Yes or No
    a. Left or Right or Both
15. Have you experienced recent Weight Loss? Yes or No
16. Have you experienced recent Weight Gain? Yes or No
17. Are you currently being treated by a Physical Therapist or Occupational Therapist? Yes or No
18. What is the name of your Therapist, name of the facility, and reason for Therapy?

    _____

    _____

19. Please tell us why you were referred to our office for care?

    _____

    _____

    _____

20. Is the injury work related? Yes or No
21. Is the injury due to recent surgery? Yes or No
22. What recreational activities would you like to return to?

    _____

    _____

    _____

23. Do you have anyone at home, helping you with everyday Activities? Yes or No
24. If you answered yes to number 23, who helps you?

    _____

    _____