

PATIENT QUESTIONNAIRE FORM

PATIENT'S NAME			GENDER
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CURRENT WEIGHT	HEIGHT	PRIMARY DIAGNOSIS	

1. Have you worn an Orthotic Device (*brace*) previously for this condition? YES NO *If Yes, when?* _____
2. Have you worn a Prosthetic Device (*artificial limb*) previously? YES NO *If Yes, when?* _____
3. Have you worn Diabetic or Therapeutic Shoes previously? YES NO *If Yes, when?* _____
4. Have you worn Shoe Inserts before? YES NO *If Yes, when?* _____
5. Are you Diabetic? YES NO *If yes, are you Insulin Dependant?* YES NO
6. Have you had any surgeries in the past five (5) years relating to the condition you are seeing us for? YES NO
If Yes, please complete next section

WHAT TYPE OF SURGERY(S)?	WHAT YEAR(S)?	NAME OF HOSPITAL(S)	NAME OF SURGEON(S)

7. Do you have Foot or Leg Pain? *If yes, which?* Foot Leg *If yes, which side?* Right Left
8. Do you have Weakness of the Leg or Ankle? *If yes, which?* Leg Ankle *If yes, which side?* Right Left
9. Do you have any swelling? *If yes please explain* _____
10. Are you currently wearing shrinkers or compression garments? Explain. _____
11. Are you an amputee? YES NO *If yes, Date and Site of amputation:* _____
12. Have you experienced recent Weight Gain? YES NO or Weight Loss? YES NO ? LBS _____
13. Have you ever been treated by a Physical Therapist or Occupational Therapist? YES NO

NAME OF THERAPIST(S)?	WHAT YEAR(S)?	NAME OF THERAPY FACILITY(S)	REASON FOR THERAPY

14. Please tell us why you were referred to our office for care:

15. Is your condition related to a recent work injury? YES NO *(If yes, please ask receptionist for a Work Comp Form)*