PATIENT QUESTIONNAIRE FORM

PATIENT'S NAME			GENDER
			☐ MALE ☐ 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*)

© 2006 All Rights Reserved – O&P Business Solutions