ORTHOTIC FOLLOW UP

INTAKE FORM

Patient _____ **EMR #** _____

OBJECTIVE / INFO / GENERAL

Assistive device you use daily? __ None __ Crutches __ Cane __ Quad Cane __ Walker __ Rollator __ Wheelchair

When was you last physician visit?

Do you have any <u>comments</u> concerning the brace?

Do you have any <u>complaints</u> concerning the brace?

Change in Volume (swelling)**?**

Change in Activities (Increase or decreases)**?**

Other concerns?

PAIN *(With Brace)*

Level of pain **<u>standing</u>**: *LOW* 0 1 2 3 4 5 6 7 8 9 10 HIGH

Level of pain **<u>walking</u>**: *LOW* 0 1 2 3 4 5 6 7 8 9 10 HIGH

Location of Pain *(Be specific)*? _____

How far can you currently walk with the brace :

__ 15 ft __ 30 ft __ 100 ft __ 150 ft __ 200 ft __ 300 ft __ ¼ mi __ ½ mi __ 1 mi __ 2 mi __ Unlimited

How many hours per day are you wearing the brace? _____ Hours

How many days per week are you using the brace? _____ Days

OBJECTIVE / EXAMINATION

Do you have any skin irritations? __ No __Yes

If Yes, Explain: _____

ADDITIONAL COMMENTS

Do you have any additional comments about the brace or service that you have received?

I attest that all information is true. I have not been coerced or coached while completing this document. Patient's

Signature: _____ **Date:** _____

FOLLOW UP Office Use Only

OBJECTIVE / GENERAL

Patient compliance: __ Great __ Good __ Acceptable Remarks:

Patient Remarks:

OBJECTIVE / EXAMINATION

Skin: __ No Irritations __ Abrasion/Blister __ Infection __ Discoloration :

__ Other:

Device Concerns:

Modifications: ___ None Other: _____

Gait with orthosis: _____ Normal _____ Antalgic Other Deviation: _____

Stability improvements:

Ankle: __ Sag __ Coronal __ Tran **Knee:** __ Sag __ Coronal __ Tran **Hip:** __ Sag __ Coronal __ Tran

OUTCOMES

OUTCOMES: ___ 10 Meter ___ Time up and Go

Self-Selected: Trial 1: ___ Min ___ Sec. **Trial 2:** ___ Min ___ Sec. **Trial 3:** ___ Min ___ Sec.

Fastest Safe: Trial 1: ___ Min ___ Sec. **Trial 2:** ___ Min ___ Sec. **Trial 3:** ___ Min ___ Sec.

Comparison to Eval:

GOALS

Goal statement:

PLAN/ TREATMENT PLAN

Plan Notes:

Appointment:

___ PRN ____ Week follow up ____ Other: _____