ORTHOTIC EVAL - LOWER (AFO, KAFO, KO) ***INTAKE FORM***

Patient ______________________________ **EMR #** ____________________

Age: ____ **Weight:** _______ lbs. **Height:** ___ ft. ____ in.

Cause of Condition: __ Accident __ Stroke __ Disease __ Polio __ Congenital __ Other: ________________

Date of injury / instability: MM / DD / YYYY

Description of injury or illness: ____

Falls: ___ falls in the last 1 month. ___ falls in the last 6 months. ___ falls in the 12 year.

OBJECTIVE / INFO / GENERAL 1

Have you used a brace before to treat this injury / illness? __ No __ Yes **If Yes, type of brace:** ___________________

If Yes, When did you receive the brace? MM / DD / YYYY

If Yes, Why is the Brace not working or not used? __ Broken __ No longer fits __ Other: ____________________

If Yes, Pain level with previous/current brace: Level of pain: *LOW* 0 1 2 3 4 5 6 7 8 9 10 HIGH

PAIN *(Without Brace)*

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

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

Location of Pain ***(Be specific)***? ____

Areas of Upper body affected: __ No __ Yes If Yes, Explain: ______________________________

Upper body Strength? __ Poor __ Fair __ Good __ Excellent

Other Areas affected: __ Foot __ Ankle __ Knee __ Hip __ Other: ______________________________

Shoe Size: _________

How far can you currently walk: __ 15 ft __ 30 ft __ 100 ft __ 150 ft __ 200 ft __ 300 ft

__ ¼ mi __ ½ mi __ 1 mi __ 2 mi __ Unlimited

OBJECTIVE / HISTORY

Living Status: __ Alone or without assistance __ Home with assistance Name & Relationship: _________________

__ Long Term Facility. Facility Name: _________________________ __ Other: _________________________

Environmental Barriers: __ Carpet __ Stairs __ Uneven __ Terrain __ Loose Grave __ Sloped Driveway

Other obstacles that you have difficulty with: ____

Chief Complaints / Describe the complications the injury / instability has caused: ______________________________

____

Date of Last Physicians Visit? MM / DD / YYYY **Physician that referred you to Victory:** ______________________

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

OBJECTIVE / HISTORY - MEDICAL/SURGICAL

List any Surgeries you have had had in the past :

Ankle: ____________________ **Knee:** ____________________ **Hip:** ____________________

__ **Surgery Scheduled on:** MM / DD / YYY **For:**____________________ **Surgeon:** ____________________

OBJECTIVE / HISTORY – ADDITIONAL TREATMENT

Attending Physical Therapy? __ No ___ Yes

If Yes, Location of therapy: ____________________ Therapist: ____________________

Frequency of therapy: ___ Days a week Length of Time: ___ Weeks __ Months

Reason for Therapy? __ strengthening __ Gain range of motion __ other: __________

Attending Occupational Therapy? __ No ___ Yes

If Yes, Location of therapy: ____________________ Therapist: ____________________

Frequency of therapy: ___ Days a week Length of Time: ___ Weeks __ Months

Reason for Therapy? __ Post-surgery __ Muscle Strengthening __ Avoid surgery __ Other: ____________

OBJECTIVE / HISTORY – PAST ORTHOSIS

Have you used a brace before to treat this injury / illness? __ No __ Yes **If Yes, type of brace:** ________________

If Yes, When did you receive the brace? MM / DD / YYYY

If Yes, Pain level with previous/current brace: Level of pain: *LOW* 0 1 2 3 4 5 6 7 8 9 10 HIGH

Reason for not using previous brace? ____

OBJECTIVE / HISTORY – ACTIVITIES

Currently Employed: ___ No ___ Yes **If Yes,** Job Title: ______________ __Full Time __ Part Time

Job Description /Activities : ____

How has this injury or illness affected you Job? ____

List your daily activities and recreational activities: ____

____

How has as injury instability affected your daily and recreational activities? ____________________

What goals would you like to accomplish while wearing Brace/Orthosis?

__ Walk without fear of falling __ Gain stability of effected joint __ Ambulate without assistive device __ Walk without pain

__ Avoid Surgery __ Return to work __ Return to independent living __ Take care of my daily needs (cooking, cleaning, hygiene)

__ Other: ____

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

Signature: ______________________________ **Date:** ____________________

EVALUATION Office Use Only

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.

ANKLE FOOT	ROM		STRENGTH		HIP	ROM		STRENGTH	
	LEFT	RIGHT	LEFT	RIGHT		LEFT	RIGHT	LEFT	RIGHT
D. Flex	0 - 20	0 - 20	/5 + -	/5 + -	Flexion	0 - 125	0 - 125	/5 + -	/5 + -
P. Flex	0 - 45	0 - 45	/5 + -	/5 + -	Extension	0 – 30	0 – 30	/5 + -	/5 + -
Inver.	0 - 35	0 - 35	/5 + -	/5 + -	Adduct	0 – 20	0 – 20	/5 + -	/5 + -
Ever.	0 - 25	0 - 25	/5 + -	/5 + -	Abduct	0 – 45	0 – 45	/5 + -	/5 + -
Hal. Flex	0 - 30	0 - 30	/5 + -	/5 + -	Int. Rot.	0 – 40	0 – 40	/5 + -	/5 + -
Hal Ext.	0 - 80	0 - 80	/5 + -	/5 + -	Ext. Rot.	0 – 60	0 – 60	/5 + -	/5 + -

KNEE	LEFT	RIGHT	LEFT	RIGHT
Flexion	0 – 145	0 – 145	/5 + -	/5 + -
Extension	145 – 0	145 – 0	/5 + -	/5 + -

Additional Notes:

FOOT TYPE: Normal Cavus Planus Equinus Equinovalgus Equinovarus Cavovarus Other: ___________________________

WEIGHT BEARING CHANGES:

Mid Foot: Over pronation - Mild Moderate Severe Supinated **Hind Foot:** Neutral Varus Valgus **Fore Foot:** Neutral Varus

Other: ____

GAIT _____ Normal ______ Antalgic Other Deviation: ____

-Deviations-

1st Rocker: Mid Foot Contact Forefoot Contact Other:

2nd Rocker No 2nd Rocker Everted Inverted Tibia Decline Early Heel Rise Other:

3rd Rocker No 3rd Rocker Everted Inverted No Push Off Other:

INSTABILITIES

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

GOAL OF ORTHOSIS __ Assist Movement __ Limit Motion __ Immobilize __ Multiplane Stability

BRACE TYPE: __ AFO __ KAFO **CATAGORY:** __ OTS __ CUSTOM

IF AFO: __ Arizona __ Ritchie __ Ritchie DA __ Metal DU __ DSAFFO __ Solid AFO __ Hinged AFO

Other:________________________________

SHOE: __ NO __ YES Brand: Style: Part #: Color:

Measurements: Left: Right: Size ordered:

SHOE MODS: __None __ Fore foot Rocker __ Full Rocker __ Lateral Flare __ Medial Flare __ Buttress w/Flare

FOOT ORTHOTIC: __ None __ Diabetic __ Functional __ FO Mods:

CAST: __ No, Waiting for Authorization __ No, Item is OTS __ Yes, Date Cast Taken MM / DD / YYYY

FABRICATION: __Victory LAB C- Fab: __ Langer /Arizona __ Maine __ Other:

TREATMENT PLAN: __ Awaiting Authorization Before fabrication __ Awaiting Fabrication prior to schedule delivery

__ Schedule for delivery __ Scheduled for casting __ Schedule Diagnostic fitting