

PEDORTHIC INTAKE



PATIENT: _____ AGE: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs.

Are you a Diabetic? No Yes If yes, for how long? _____ Years

Hours per day on your feet? _____ Hours

Shoe Size: _____ Shoe Style worn most of the time: Walking Athletic Casual

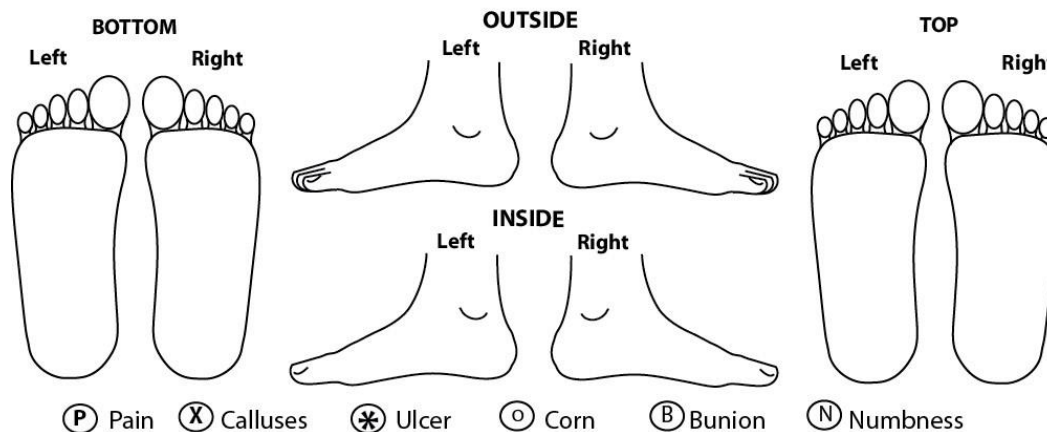
Shoe Wear: Like to go barefoot Occasionally Most of the time Wear shoes all the time

FOOT CONDITIONS (Check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Foot Ulcers | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Bunions | <input type="checkbox"/> Toe amputation |
| <input type="checkbox"/> Calluses | <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Overlapping Toes | <input type="checkbox"/> Partial Foot Amputation |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Burning Sensation | <input type="checkbox"/> Hammer Toes | <input type="checkbox"/> Foot surgery |
| <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Swelling in Feet |

Other foot conditions: _____

INDICATE LOCATION OF FOOT CONDITIONS



PAIN Level of pain: 0 1 2 3 4 5 6 7 8 9 10
 Low Moderate High

TOE OR PARTIAL FOOT AMPUTATIONS

No Yes If yes, Level Toe Partial Foot Not sure Amputation Date: _____

GOALS

What do you wish to accomplish by using an orthotic device?

Has your foot condition affected your work and or daily activities?

Diagnosis: Diabetic Neuropathy Pain P-Fasciitis Charcot

Foot Type: Normal Cavus Planus Equinus Equinovalgus Equinovarus Cavovarus

Foot/Ankle ROM (Open Chain)

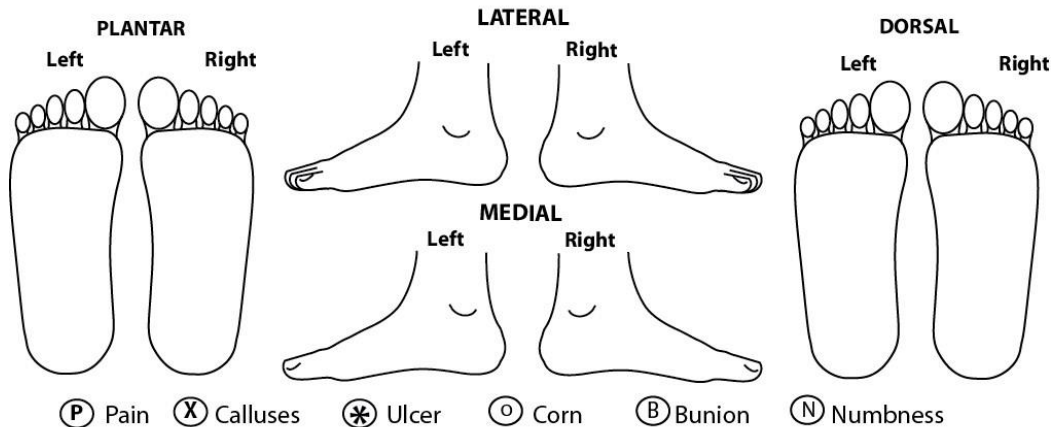
LEFT D. Flex 0 - 20 P. Flex 0 - 45 Inv. 0 - 35 Ever. 0 - 25 Hal. Fl. 0 - 30 Hal Ext. 0 - 80
RIGHT D. Flex 0 - 20 P. Flex 0 - 45 Inv. 0 - 35 Ever. 0 - 25 Hal. Fl. 0 - 30 Hal Ext. 0 - 80

Weight bearing Changes: Mid Foot: Over pronation (Mild Moderate Severe) Supinated
Hind Foot: Neutral Varus Valgus Fore Foot: Varus

Other: _____

Toes: Hallux Rigidus / Limitus Hammer Toes Neutral Crossing over

Plantar Surface: Normal padding Loss of fat pad under fore foot. Thin fragile skin



Monofilament test results: _____

Other Concerns: _____

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:

SHO _____

Brand:

Style:

Part #:

Color:

Requirements

Left:

Right:

Size ordered:

MODIFICATIONS

Fore foot Rocker

Full Rocker

Lateral Flare

Medial Flare

Buttress w/Flare

ORTHOTIC

Diabetic

Functional

OTS

Custom

If custom, Impression type:

Foam Box

Scan

MODIFICATIONS

/ LAB

Wedge

C- Fab:

Lateral

Langer

Medial

Other:

Heel

Full Length

1/2

1/4

FABRICATION