Orthotic Health History Form

Name: ______________________________ Date of Birth: ____________ Age:____ Sex: ☐ M ☐ F
Address: _______________________ City: _____________ Province: ____ Postal Code: _____
Home Phone: _________ Work Phone: ___________ Occupation: _________________________
How did you hear about our office?____
Do you have insurance? Yes ____No______
If yes, who is your insurance company? ____

Please check and explain conditions, which apply to you:

- ☐ Arch pain ____
- ☐ Heel pain ____
- ☐ Toe pain____
- ☐ Bunions ____
- ☐ Hammer toes ____
- ☐ Ankle pain ____
- ☐ Calf pain ____
- ☐ Knee pain ____
- ☐ Thigh pain ____
- ☐ Hip pain ____
- ☐ Low back pain ____
- ☐ Upper back pain ____
- ☐ Neck pain ____
- ☐ Headaches ____
- ☐ Abnormal gait ____
- ☐ Other ____

Have you ever broken, injured or had surgery to your:

Toes	YES	NO
Feet	YES	NO
Ankles	YES	NO
Knee	YES	NO
Leg	YES	NO
Hip	YES	NO
Back	YES	NO

Do you have diabetes?	YES	NO
Do you have arthritis?	YES	NO
Do you think you have a leg length difference?	YES	NO
Do you currently wear orthotics?	YES	NO
Have you ever worn orthotics?	YES	NO
Do you participate in sports?	YES	NO

If so, what type? ____
Shoe size: _________ Body weight: _________
Type of shoes worn: ____

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