**Orthotic Intake Form**

**Thank you for taking the time to fill out this form. Please take your time as your answers will help us to better serve you.**

**Name:** Click or tap here to enter text.

**Diagnosis or condition associated with prescribed device:**   Accident  Stroke  Disease

Multiple Sclerosis  Polio  Congenital  Other: Click or tap here to enter text.

**Describe issue(s) you are having related to why you are here:**

Click or tap here to enter text.

**Date of injury / instability:** MM / DD / YYYY Description of injury or illness:

Click or tap here to enter text.

**Other medical condition(s):** Click or tap here to enter text.

**HISTORY**

**Have you used a brace before to treat this injury / illness?**

No  Yes If Yes, type of brace(s): Click or tap here to enter text.

If Yes, When did you receive the brace? MM / DD / YYYY Click or tap here to enter text.

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

Click or tap here to enter text.

**ACTIVITY LEVEL**

**List your daily activities and recreational activities:**

Click or tap here to enter text.

**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:

Click or tap here to enter text.

**LIVING STATUS**

Alone or without assistance  Home with assistance Long Term Facility.   
Facility Name: Click or tap here to enter text. Other: Click or tap here to enter text.  
  
**Environmental Barriers:**  Steps Carpet  Stairs  Uneven Surfaces  Terrain  Loose Grave

Sloped Driveway

**Assistive device you use daily:**  None  Crutches  Cane  Quad Cane  Walker Wheelchair

**PAIN, DISCOMFORT OR DIFFICULTY WALKING**

**Pain level without current brace:** LOW 0  1  2  3  4  5  6  7  8  9  10 HIGH PAIN

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

**Pain level with current brace:** LOW 0  1  2  3  4  5  6  7  8  9  10 HIGH PAIN

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?

Click or tap here to enter text.

**Anything else you would like to let us know to optimize your orthotic care?:**

Click or tap here to enter text.

**Signature:** **Date:** MM/DD/YYYY

Click or tap here to enter text. Click or tap here to enter text.

Electronically signed