**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