



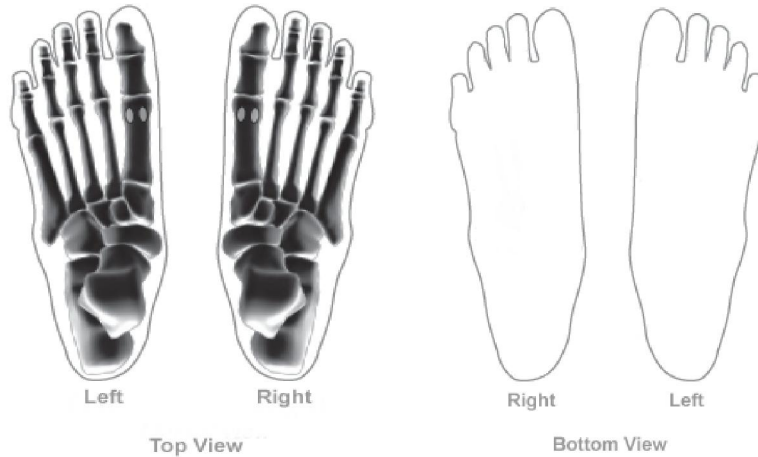
**CUSTOM ORTHOTICS FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Please let us know if you experience any symptoms of faulty foot mechanics such as:

- |                                   |     |    |
|-----------------------------------|-----|----|
| 1) Localized Foot Pain            | YES | NO |
| 2) Bunions, Calluses, Hammer toes | YES | NO |
| 3) Arch/heel Pain                 | YES | NO |
| 4) Leg/knee Pain                  | YES | NO |
| 5) Hip or back Pain               | YES | NO |

Please draw and label any problems that you are aware of on the pictures below:



What shoes do you wear most often? \_\_\_\_\_

What shoes are the most comfortable? \_\_\_\_\_

How many hours do you spend a day on your feet? \_\_\_\_\_

Have you worn orthotics before? YES NO

What is your primary concern about your feet? \_\_\_\_\_

What do you hope to achieve in this visit today? \_\_\_\_\_



**Clinical Assessment:**

<b>Foot Type:</b> <b>nwb</b> <b>wb</b> high arch      L / R      L / R medium arch      L / R      L / R low arch      L / R      L / R		<b>Subtalar Joint:</b> hypermobile      L / R within normal limits      L / R limited      L / R	<b>1st Ray Position:</b> plantarflexed      L / R normal      L / R dorsiflexed      L / R
<b>Hallux Dorsiflexion:</b> Normal      L / R Limitus      L / R Rigidus      L / R		<b>Ankle Dorsiflexion:</b> Normal      L / R Limited      L / R	<b>Knee Position:</b> <input type="checkbox"/> genu varum      L / R <input type="checkbox"/> genu valgum      L / R <input type="checkbox"/> recurvatum      L / R <input type="checkbox"/> fixed flexion      L / R <input type="checkbox"/> straight      L / R <input type="checkbox"/> Q angle: L: ___°    R: ___°
<b>Leg Length Discrepancy:</b> ASIS to med. Malleolus: Left: ___ cm    Right: ___ cm		<b>Tibial Torsion:</b> internal      L / R external      L / R wnl      L / R	
<b>Gait:</b> <i>Left</i>	<i>Right</i>	<b>Measurements:</b> <u>Non Weight Bearing:</u> Calcaneal Inversion      L: ___° varus/valgus    R: ___° varus/valgus Calcaneal Eversion      L: ___° varus/valgus    R: ___° varus/valgus Neutral Calculation      L: ___° varus/valgus    R: ___° varus/valgus Forefoot      L: ___° varus/valgus    R: ___° varus/valgus <u>Weightbearing:</u> Calcaneus      L: ___° varus/valgus    R: ___° varus/valgus Tibial Varum      L: ___°    R: ___°	

**Office Notes:**

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**Need for Orthotics:**    zero    low    low-medium    medium    medium-high    high