PROrthotics & OT, LLC

HISTORY FORM

Today's Date: _____ Patient's current Height: _____ Weight _____

Completed by _____ Relationship to patient: _____

Patient's Name: _____ Birthdate: _____ Age: _____

Primary Physician _____Physician's Phone # _____

Does patient have any allergies? _____ yes _____no If so, to what? _____

Reason for today's visit: _____

If patient was injured, how did it occur? _____

What other specialists has patient seen (Orthopedics, Neurology, Cardiology, etc) ? _____

_____

Medical Diagnosis(es): _____

Therapies: List type, location and duration: _____

Please list any current medications and reason for use: _____

Brief Medical History: Please list all illness, conditions patient has experienced: _____

_____

Surgical procedures (non-orthopedic): _____

Orthopedic surgery/type/date: _____

Athletic activities (level, days per week) _____

What types of brace/splint/orthosis has patient worn in the past? _____

_____

What did you like or dislike about the design/function of the orthosis? _____

What function would you like the new device to perform or assist with? _____

What are your concerns related to the new device?_____