chicago **wellness** center

Test your need for Orthotic Support and GaitScan^{tm} Gait Analysis

Patient Name: _____

Occupation/Activity: _____

Date of Birth: ___ / ___ / _____

Weight: _____

Shoe Size: _____

Shoe Type (circle all that apply): *Athletic* *Dress* *Casual* *Other*_____

1. My feet are sore on a regular basis	yes	no
2. I spend a good portion of my day standing or walking on hard surfaces	yes	no
3. I play a sport or exercise regularly List your activities: _____	yes	no
4. Standing, walking, or running gives me joint pain please circle: *ankles* *knees* *hip* *back* *other*_____	yes	no
5. I am over 40 years old	yes	no
6. I have visible foot problems please circle: *bunions* *fallen arches* *corns* *callusing* *other*_____	yes	no
7. One of my legs is shorter than the other	yes	no
8. I have knock-knees or bow-legs	yes	no
9. My shoes wear out quickly or unevenly Give details: _____	yes	no
10. My feet “toe-out” when I walk	yes	no
11. My parents had foot related symptoms	yes	no