



## Test your need for Orthotic Support and GaitScan™ 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   | yes | no |
| List your activities: _____   |     |    |
| 4. Standing, walking, or running gives me joint pain  | yes | no |
| please circle: <i>ankles</i> <i>knees</i> <i>hip</i> <i>back</i> <i>other</i> _____                 |     |    |
| 5. I am over 40 years old   | yes | no |
| 6. I have visible foot problems   | yes | no |
| please circle: <i>bunions</i> <i>fallen arches</i> <i>corns</i> <i>callusing</i> <i>other</i> _____ |     |    |
| 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  | yes | no |
| Give details: _____   |     |    |
| 10. My feet "toe-out" when I walk   | yes | no |
| 11. My parents had foot related symptoms  | yes | no |