CEDAR HILL
Sports Therapy Clinic

Orthotics: Confidential Medical Health History

Name:_____

Please describe your **current symptoms** that you are hoping orthotics will help with: _____

_____

When did these **symptoms begin**: _____

Have you had this condition before? Yes ◯ No ◯ If so, when? _____

Have you received therapies for these symptoms? Chiropractic / Physiotherapy / Acupuncture / Other:_____

Please list the **intended uses** for your orthotics (including fitness/recreational activities):_____

_____

Occupation: _____ Please indicate how much of your day is spent on your feet?_____

Recreational/fitness activities/fitness programs? _____

Have you had orthotics in the past? Yes ◯ No ◯ If so, when? _____

What are your **preferred shoe types**? _____

Weight: _____ **Height: _____** **Shoe Size**: _____

Please circle any of the following that **apply to you**:

Cancer	Diabetes	Osteoporosis	High/Low Blood Pressure	Heart Disease	Rheumatoid Arthritis/Osteoarthritis
Polio	Allergies	Pregnancy	Skin Condition	Dizziness	MS/Neurological Conditions
CMT	CP	Other:_____			

Have you had any **lower leg extremity surgeries**? Yes ◯ No ◯ If yes, Date(s)? _____

If yes, please describe _____

Name of **referring medical practitioner**: _____

Do you have a **prescription** for orthotics: _____

Do you have extended health coverage? Yes ◯ No ◯ If so, name of insurer: _____

To the best of my knowledge the above is a true statement of my physical condition.

Signature:_____ Date(MM/DD/YYYY): __ __/__ __/__ __ __ __