

PATIENT HEALTH QUESTIONNAIRE

Patient's First Name	MI	Last Name	Date of Birth
Current Weight	Height		

1. Who is your Primary Physician? _____
2. Do you have an Orthopedic Surgeon, Neurologist, or Podiatrist? YES NO
What is their name? _____
3. Do you have a Physical Therapist or Occupational Therapist? YES NO
What is their name? _____
4. Who referred you to our office? _____
5. Do you have any allergies to medications, latex, or other? YES NO
Please list: _____
6. Are you having problems with any of the following areas? *Please check of all that apply*
 Neck Back Knee Ankle Foot
 Arm Wrist Finger Hip Other: _____
 If you checked any of the boxes above, please tell us how long have you had these problems?
 _____ days _____ weeks _____ months _____ years
7. Do you have problems walking, bending, or standing? YES NO
If yes, explain _____
8. Do you have foot or leg pain? YES NO
If yes, explain _____
9. Do you have leg or ankle weakness? YES NO
If yes, explain _____
10. Are you a Diabetic? YES NO *If yes, are you Insulin Dependent* YES NO
11. Have you ever worn a Leg Brace, AFO or KAFO? YES NO
If yes, what Side? Left Right Both How Long? _____ When did you get your last brace? _____
12. Have you ever worn a Back Brace, LSO or TLSO? YES NO
If yes, How Long? _____ When did you get your last brace? _____
13. Have you ever worn Diabetic Shoes? YES NO
If yes, How Long? _____ When did you get your last pair? _____
14. Have you ever worn a Prosthesis? YES NO
If yes, what Side? Left Right Both How Long? _____ When did you get your last brace? _____
15. Have you ever worn Foot Orthotics or inserts? YES NO
If yes, what Side? Left Right Both How Long? _____ When did you get your last pair? _____
16. Have you had any surgeries within the past five years? YES NO *If yes, please complete the next section*

Type of Surgery	Year	Name of Hospital	Name of Surgeon

17. Are you taking any medications? YES NO *If yes, please list* _____

Patient's Signature _____ Date Signed _____