

LOWER EXTREMITY INTAKE FORM



Patient's Name: _____ Age: _____ Date: _____

DOB: _____ Height: _____ Weight: _____ Shoe Size: _____

Does patient stand or walk on hard surfaces? Yes No Hours Per Week: _____

Related Complaints:

- FLAT FEET
- BUNIONS
- CORNS
- OTHER: _____
- PAIN WHILE STANDING
- PAIN WHILE WALKING
- PAIN WHILE RUNNING

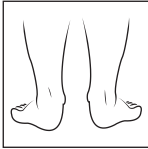

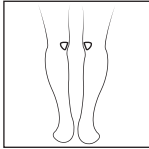
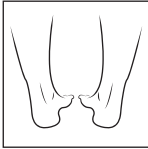

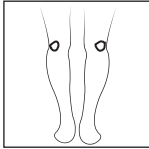
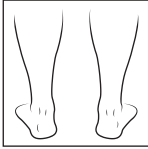


History of problems/injuries to:

- FEET
- KNEES
- HIPS
- SPINE
- ANKLES
- LEGS/PELVIS
- OTHER: _____

Recreational Activities:

- WALKING
- GOLF
- BOWLING
- VOLLEYBALL
- BASEBALL
- WEIGHT-LIFTING
- Other: _____
- RUNNING
- TENNIS
- CYCLING
- BASKETBALL
- FOOTBALL
- AEROBICS

Foot Screening:

Walking Gait		Standing Arch/Palpation		Standing Patella Alignment	
1 <input type="checkbox"/>		1 <input type="checkbox"/>		1 <input type="checkbox"/>	
Left Foot		Right Foot		Right Foot	Right Knee
	1 <input type="checkbox"/>		1 <input type="checkbox"/>		1 <input type="checkbox"/>
	Right Foot		Left Foot		Left Knee
<i>Toe-Out</i>		<i>Low (Pronation)</i>		<i>Inwardly Rotated</i>	
2 <input type="checkbox"/>		2 <input type="checkbox"/>		2 <input type="checkbox"/>	
Left Foot		Right Foot		Right Foot	Right Knee
	2 <input type="checkbox"/>		2 <input type="checkbox"/>		2 <input type="checkbox"/>
	Right Foot		Left Foot		Left Knee
<i>Toe-In</i>		<i>High (Supination)</i>		<i>Outwardly Rotated</i>	
3 <input type="checkbox"/>		3 <input type="checkbox"/>		3 <input type="checkbox"/>	
Left Foot		Right Foot		Right Foot	Right Knee
	3 <input type="checkbox"/>		3 <input type="checkbox"/>		3 <input type="checkbox"/>
	Right Foot		Left Foot		Left Knee
<i>Straight</i>		<i>Normal</i>		<i>Straight</i>	

Functional Movement Screen:

Overhead Squat

- Pain with movement
- Inability thighs coming parallel to floor
- Anterior patella shearing
- Inability to maintain neutral spine
- ≈ Hip hinge
- Knee valgus
- Heels lift
- Hyperpronation
- Inability arms maintain parallel OH

Select

Single Leg Stance

- Pain with movement
- Unable to stand EO x 10 sec
- Unable to stand ECd x 10 sec
- Trendelenberg Sign
- No toe grabbing R L
- Foot pronation R L

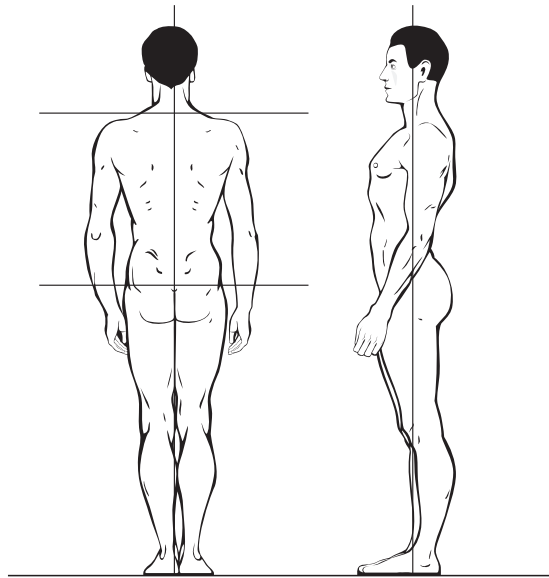
Select

Doctor's Name: _____

Left

Right

Head Tilt/Rotation
 High Shoulder
 Axillary Space Inc/Dec
 Lat Curve Apex
 High Hip
 Torso Rotation
 Femoral Rot. Int/Ext
 Genu Valgum/Varum
 Pes Planus/Cavus
 Toe-In/Toe-Out



Head Tilt/Rotation
 High Shoulder
 Axillary Space Inc/Dec
 Lat Curve Apex
 High Hip
 Torso Rotation
 Femoral Rot Int/Ext
 Genu Valgum/Varum
 Pes Planus/Cavus
 Toe-In/Toe-Out

Anterior Head Translation
 BackHyperkyphosis
 Anterior Pelvic Tilt

Shoulder Protraction
 Hyperlordosis
 Genu Recurvatum

Sway
 Hypolordosis

Additional Findings: _____

Gait Analysis

Trunk _____

Pelvis _____

Hip _____

Knee _____

Ankle _____

Recommendations

Foot Levelers Custom Orthotics

Pair 1: _____

Pair 2: _____



M11719-0620