



Date in:	
Date out:	
Number:	

PATIENT INFORMATION

CLINIC INFO: _____ First Name: _____ Last Name: _____
 _____ Weight lbs: _____ Gender: _____ Shoe Size: _____ Type of shoes: _____

BIOMECHANICAL EXAMINATION FINDINGS

Arch Height: Non-Weight Bearing High Medium Low
 Arch Height: Weight Bearing High Medium Low
 Metatarsal Adductus Rear Foot Varus Fore Foot Valgus
 Rear Foot Valgus Fore Foot Valgus
 Gait Pattern: Out toe In toe Straight
 Hallux: Valgus Limitus Rigidus Pes Planus Pes Cavus
 Right
 Left

1. TYPES OF ORTHOTICS

SPORT MEDIX MARATHON SUPER FLEX SAFETY MEDIX
 CASUAL MEDIX DRESS HIGH HEEL
 ACCOMMODATIVE DIABETIC : EVA Cork Polypropylene (Thin)
 UCBL ROBERT WHITMAN
 Induce in-toeing Induce out-toeing
 Heel Cup Depth 10mm 12mm 15mm Other _____
 Cast Dressing Min Moderate Max
 Shell Cut Out Standard Wide Narrow
 PREMIUM* XT SPORT MEDIX XT CASUAL MEDIX XT DRESS MEDIX

2. TYPES OF BACK COVERS

Vinyl: Black Navy Suede*: Black Tan Brown
 Microcell: Black Green Red Navy

3. TYPES OF TOP COVERS

Vinyl <input type="radio"/> Black <input type="radio"/> Navy <input type="radio"/> Brown <input type="radio"/> Red <input type="radio"/> Grey	Spenco ETC <input type="radio"/> Black <input type="radio"/> Blue <input type="radio"/> Navy	Microcell <input type="radio"/> Black <input type="radio"/> Navy <input type="radio"/> Red <input type="radio"/> Green <input type="radio"/> Brown <input type="radio"/> Yellow	Kids <input type="radio"/> PPNW <input type="radio"/> GRYN <small>P:Pink, P:Purple N:Navy, W:White G:Green, R:Red Y:Yellow</small>	Leather* <input type="radio"/> Black <input type="radio"/> Brown <input type="radio"/> Beige	Suede* <input type="radio"/> Black <input type="radio"/> Tan <input type="radio"/> Brown
EVA - Perforated <input type="radio"/> Black <input type="radio"/> Beige		X Static* (Antibacterial) <input type="radio"/> Black			

4. CUSHION AND POSTING

Shell Thickness 1 mm 2 mm 3 mm Other _____
Length Full Length 3/4 (to Mets) Sulcus
Cushion Mid Layer None 2 mm 3 mm Extra _____
Rearfoot Extrinsic Intrinsic
 Left Varus _____ Valgus _____
 Right Varus _____ Valgus _____
Forefoot Extrinsic Intrinsic
 Left Varus _____ Valgus _____
 Right Varus _____ Valgus _____
 Ext to Sulcus
Heel Lift Left _____ mm Right _____ mm

5. MODIFICATIONS: SOFT & HARD

<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> (1, 2, 3, 4, 5) L <input type="checkbox"/> (1, 2, 3, 4, 5) R	<input type="checkbox"/> (1, 2, 3, 4, 5) L <input type="checkbox"/> (1, 2, 3, 4, 5) R	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> (1, 2, 3, 4, 5) L <input type="checkbox"/> (1, 2, 3, 4, 5) R
<input type="checkbox"/> Left <input type="checkbox"/> Right	_____ mm <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hard <input type="checkbox"/> Soft	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hard <input type="checkbox"/> Soft	R <input type="checkbox"/> Medial _____ mm R <input type="checkbox"/> Lateral _____ mm L <input type="checkbox"/> Medial _____ mm L <input type="checkbox"/> Lateral _____ mm			
<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right		

7. ADDITIONAL REQUESTS