



FOOTCARE QUESTIONNAIRE

DATE: _____

CLIENT NAME: _____

ADDRESS: _____

PHONE: (home/work/cell) _____ BIRTH DATE: _____

Height _____ Weight _____ Foot Size _____ M/F (circle)

1) Do you have: Diabetes yes no Arthritis yes no

If you have entered yes to any of the above questions, do any of these conditions affect your feet?
yes no If yes, please explain:

2) For the following body areas, indicate the severity of pain you experience on a scale of 1 to 10, with 10 being the most severe. **None** **Shin Splints** yes no

Ankle right left **Heel** right left **Toe** right left **Arch** right left

Leg right left **Knee** right left **Hip** right left **Low Back** right left

Have you had surgery to any of the above areas? yes no

3) Is your pain/fatigue occasional, sporadic or constant? (please circle one)

4) During which work/recreational activity do you experience pain/fatigue?

5) Do you wear or have you worn orthotics? yes no

6) Please indicate any foot conditions from which you may suffer: calluses corns flat feet bunions hammer toes heel spurs neuroma none other

7) With respect to work activities, which best describes your workday? sitting standing stair climbing walking lifting The lifting I do is: (0-29lbs) (30-75lbs) (76lbs+)

8) Are your legs or feet tired at the end of the day? yes no

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