IN STEP ORTHOTICS

CONSULTATION ADMITTANCE FORM

Name:_____ _____ _____

Surname First Initial

Date of Birth: D_____/M_____/Y_____ Weight: _____ Shoe Size: _____

Mailing Address: _____ Postal Code: _____

E-mail Address: _____

Telephone Numbers: Res: _____ Business: _____

Marital Status: M/ S/ D /W Gender: M F

Is this a Workman's Compensation Case? Y / N

Who referred you to our center? _____

Your major complaint or symptoms are: _____

ALL Previous surgeries, illness, and injuries:

_____

_____

Have you worn orthotics before? _____

Family Doctor's Name: _____

Orthotics are custom made, prescription based, foot corrections, as a result they are <u>non</u> refundable. In an effort to make you the most accurate orthotic we will modify your prescription once. Any further modifications will be charged to you, the patient.

Date: _____ Signature _____