STRIDE™

CUSTOM ORTHOTICS

ORTHOTIC FOLLOW-UP

Patient's Name: _____ **Date:** _____

Subjective Report:

Patients Comments: _____

Current daily usage of orthoses (hrs/day): ❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 8 or more

Orthoses fit to shoe: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Tolerance to orthoses ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Specific Complaints: ❑ Pressure (R L B) ❑ Blister (R L B) ❑ Irritation (R L B)

❑ Heel (Plantar / Medial / Lateral) R L B

❑ Lateral border of foot R L B

❑ Medial longitudinal Arch R L B

❑ Metatarsal Heads Right: 1 2 3 4 5 Left: 1 2 3 4 5

❑ Toes Right: 1 2 3 4 5 Left: 1 2 3 4 5

❑ Other: _____

Patient's initial c/o _____ has been:

❑ Completely resolved ❑ Partially resolved ❑ Unchanged

Any other adverse affects: ❑ Knees ❑ Legs ❑ Hips ❑ Back ❑ Other

Clinician's Objective Report:

Orthosis success in regard to mechanical support is:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Improvement in gait: ____Yes ____No

Any adjustments to orthosis necessary? ____Yes No____ (Specify)

Left:	Right:

Assessment:

Goals of orthosis management have been: ❑ met ❑ partially met ❑ not met

Existing shoewear is: ❑ adequate ❑ inadequate: _____

Plan:

❑ Adjustments completed and orthoses have been redispensed.

❑ Adjustments will require ____days to complete and will then be redispensed.

❑ Subsequent follow-up visit in ____weeks.

❑ Patient discharged. Long term follow-up in ____months or ____years.

Clinician's Signature: _____