



Test your need for Orthotic Support and Footlevelers Associate™ Analysis

Patient Name: _____

Occupation/Activity: _____

Date of Birth: ___ / ___ / _____

Weight: _____

Shoe Size: _____

Shoe Type (circle all that apply): *Athletic Dress Casual Other* _____

1. My feet are sore on a regular basis yes no

2. I spend a good portion of my day standing or walking on hard surfaces yes no

3. I play a sport or exercise regularly yes no

List your activities: _____

4. Standing, walking, or running gives me joint pain yes no

please circle: *feet ankles knees hip back other* _____

5. I am over 40 years old yes no

6. I have visible foot problems yes no

please circle: *bunions fallen arches corns callusing other* _____

7. One of my legs is shorter than the other yes no

8. I have knock-knees or bow-legs yes no

9. My shoes wear out quickly or unevenly yes no

Give details: _____

10. My feet "toe-out" when I walk yes no

11. My parents had foot related symptoms yes no