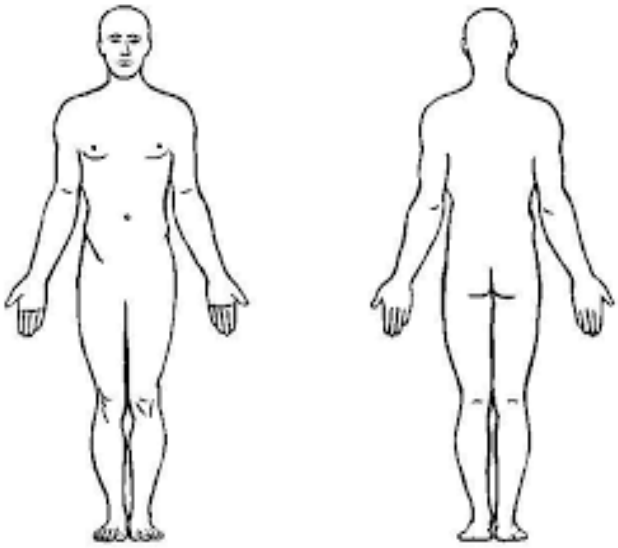
GREAT GAIT ORTHOTICS

SELF REFERRAL FORM	
Name	**DOB:**
Address: = _____ _____ _____ **GP Details: =** **Name:** _____ **Address:** _____ _____ _____	**Home telephone:** **Work telephone: ==** **Email address:** **Next of kin name and contact:** **=**
Can we leave a message on the above telephone numbers?	
Do you have any special requirements? Eg interpreter:	

Please describe current symptoms and problems:



Please mark areas of discomfort

Great Gait

Orthotics for healthy joints

Questions relating to your condition:

1) **How long have you had this problem?**

2) **Is there any underlying cause that may have started or aggravated your current symptoms eg trauma/fractures**

3) **Have you had previous treatment eg physiotherapy/steroid injections/surgery? If so please explain**

4) **Are you off work/school or unable to care for a dependent due to this problem? Please move on if this question does not apply**

5) **Does your pain/walking pattern/limb position worsen when weight bearing or is it at a constant throughout the day**

6) **Are your activities of daily living directly affected by your current symptoms?**

<u>Past Medical History:</u>

7) **Please list all conditions that you have been diagnosed with (including allergies to materials if any)**

8) **Please list all current medications you are taking (prescribed and over the counter)**

Signature:_____ Date:_____