ORTHO REHAB DESIGNS
2578 Belcastro St., Suite 101
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Video Instructions

Video Format: any format.
Wear shorts that expose your legs from mid-thigh down.
Walk on a well-lit flat surface.

Video position 1: While standing upright and still, have someone take video of you from the front, back, and each side (full body) without any orthoses or shoes, with a close-up of your feet and legs.

Video Position 2: Take video of you walking without orthoses or shoes (front and back) for approximately twenty (20) feet, walking toward and away from the camera repeatedly.

Video Position 3: Repeat position 2 while wearing your current devices (if you currently wear any).

Video position 4: Position the camera to view you walking from the side. Take video of you walking from the side, past the camera, without orthoses or shoes. Walk forward and back repeatedly for about twenty (20) feet.

Video position 5: Repeat position 4 while wearing your current devices (if you currently wear any).

Walk back and forth

Angle 1.

Angle 2.

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Diagnosis or nature of problem: _____

Normal shoe size: _____ Shoe size currently used to accommodate existing leg braces: _____

Do you have a leg length discrepancy? If so, how much: Left _____ Right _____

What joints are primarily affected (i.e.; ankle, knee, hip) _____

Have you had any surgery that affects your current condition? (Please state type of surgery and areas affected) _____

Are you using any devices to assist while ambulating? _____

Do you currently use a wheelchair? If so, explain (use most of the time, only for long trips, etc.):_____
_____

Do you have any other medical conditions? _____

Are you experiencing any balancing problems? _____

Do you have any sensory loss anywhere in your lower extremities? _____

Are you currently under the care of a physical therapist? _____

Do you have any upper extremity weakness? _____

Have you ever fallen due to lack of balance? _____

Please provide the following information:

Patient name: _____ Date of birth: _____ Height: _____

Address: _____ Weight: _____

_____

Contact name: _____ Physician name: _____

Phone number: _____ Phone number: _____

Email address: _____

*Enclose this form and the Medical Questionnaire with your video. Please attach a separate sheet or write on the back to tell us any additional information you feel is important about you and your condition.

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Medical Questionnaire

Name _____ Date_____

Do you have or have you ever had any of the following?:
Edema (swelling of the feet or legs)
Open wounds on feet
Diabetes
Difficulty with wound healing
Difficulty with skin infections
Cellulitis

Are you currently taking or using any medications?
(Please list) If none, check here ☐

Have you had any surgeries?
Back
Neck
Hips
Knees
Ankles
Feet
Asthma
Arthritis
Stroke
Heart surgery
Please explain your medical conditions (use another page if necessary):