GRACE REHAB INC. ORTHOTICS AND PROSTHETICS

PATIENT INTAKE FORM

Scheduled appointment date: ☐

PATIENT INFORMATION

Last Name :		First & Middle:		
DOB:	Gender:	Height:	Weight:	Shoe Size:
Address:				
City:	State:	Zip Code:		

PARENT/LEGAL GUARDIAN INFORMATION

Last Name:	First:	Relationship:
Primary Phone:	Email:	

CLINICAL INFORMATION

Diagnosis:		Who referred you:	
Primary Physician:	Facility	Phone:	Last Visit:
Therapist:	Facility:	Phone:	

INSURANCE INFORMATION

1	Primary Insurance:	☐ Private ☐ Medicaid ☐ Tricare ☐ Other:	
ID#:		Group #:	Phone #
2	Secondary Insurance:	☐ Private ☐ Medicaid ☐ Tricare ☐ Other:	
ID#:		Group #:	Phone #

PATIENT MOBILITY INFORMATION

Does the patient use any of the following assistive devices? ☐ None ☐ Wheelchair ☐ Stander ☐ Gait Trainer ☐ Walker ☐ Crutches

Does the patient currently use orthotics? ☐ Y ☐ N	If Yes, what kind?	Age of device:

Is the current device meeting patient's current goals? ☐ Y ☐ N If NO, please explain:

MILESTONES & GOALS (please check all that apply)

Patient is able to:

- ☐ Sit up independantly
- ☐ Crawl
- ☐ Pull to stand
- ☐ Cruise
- ☐ Ind. standing
- ☐ Ind. steps
- ☐ Squat to stand
- ☐ Independent walking
- ☐ Kick a ball
- ☐ Run
- ☐ Walk up stairs
- ☐ Jump
- ☐ Walk down stairs
- ☐ Run and stop

Patient Goals:

Parent/Therapy Goals:

Orthotic device being requested or recommended (this helps us check benefits):

SMO's - wrap just above the ankles

AFO's - extend just below the knees

Select one

Side

AND/OR

- ☐ Wrist/Hand
- ☐ Elbow
- ☐ Back/Spine
- ☐ Knee
- ☐ Other: _____

Please sign to submit: