

Orthotics & DME Questionnaire

Patient name: _____ DOB: / /
 MA/ OA name: _____ Location: _____ Date: _____
 Patient chief complaint: _____

Orthotics & DME history

- Have you used any Orthotics & DME before? Yes No
 If yes, then please specify _____
- Are you still using the previous device(s)? Yes No

Orthotics & DME services at Pohlman Pain Associates

Please indicate in the below list any devices you are interested in.
 If approved by your doctor, we will run this by your insurance for coverage and authorization prior to fulfillment.

<input type="checkbox"/> Cervical collar <input type="checkbox"/> Shoulder brace <input type="checkbox"/> Elbow brace <input type="checkbox"/> Wrist brace <input type="checkbox"/> TLSO brace <input type="checkbox"/> LSO brace Waist circumference _____ <input type="checkbox"/> Scoliosis brace Waist circumference _____ <input type="checkbox"/> Hip brace <input type="checkbox"/> Knee brace Circumference 6" above knee _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Foot Orthotics</p> <input type="checkbox"/> AFO <input type="checkbox"/> Ankle brace <input type="checkbox"/> Shoe (Model/colour) _____ </div> <div style="width: 25%; border: 1px solid black; padding: 5px;"> <p>Size _____</p> <p>Width <input type="checkbox"/> Narrow <input type="checkbox"/> Wide <input type="checkbox"/> Extra Wide</p> <p>Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> </div> </div> <p>Assistive DME</p> <input type="checkbox"/> Single point cane <input type="checkbox"/> Quad cane <input type="checkbox"/> Walker <input type="checkbox"/> Others <input type="checkbox"/> Rollator <p>Rehab DME</p> <input type="checkbox"/> TENS <p>Other Orthotics & DME _____</p>
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Special Remarks: