

BIOMECHANICAL EXAM

		Left	Right
Arch Height	High	<input type="checkbox"/>	<input type="checkbox"/>
Off Weight Bearing	Medium	<input type="checkbox"/>	<input type="checkbox"/>
	Low	<input type="checkbox"/>	<input type="checkbox"/>
Arch Height	High	<input type="checkbox"/>	<input type="checkbox"/>
Weight Bearing	Medium	<input type="checkbox"/>	<input type="checkbox"/>
	Low	<input type="checkbox"/>	<input type="checkbox"/>
Subtalar Joint	Increased	<input type="checkbox"/>	<input type="checkbox"/>
Range of Motion	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased	<input type="checkbox"/>	<input type="checkbox"/>
Relaxed Calcaneal	Inverted	<input type="checkbox"/>	<input type="checkbox"/>
Stance Position	Vertical	<input type="checkbox"/>	<input type="checkbox"/>
	Everted	<input type="checkbox"/>	<input type="checkbox"/>
Neutral Calcaneal	Inverted	<input type="checkbox"/>	<input type="checkbox"/>
Stance Position	Vertical	<input type="checkbox"/>	<input type="checkbox"/>
	Everted	<input type="checkbox"/>	<input type="checkbox"/>

		Left	Right
Foot Flexibility:	Flexible	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Restricted	<input type="checkbox"/>	<input type="checkbox"/>
First Ray Motion:	Hypermobile	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Restricted	<input type="checkbox"/>	<input type="checkbox"/>
First Ray Position	Dorsiflexed	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Plantarflexed	<input type="checkbox"/>	<input type="checkbox"/>
Hallux Limitus	None	<input type="checkbox"/>	<input type="checkbox"/>
	Moderate	<input type="checkbox"/>	<input type="checkbox"/>
	Severe	<input type="checkbox"/>	<input type="checkbox"/>
1st Met Length	Short	<input type="checkbox"/>	<input type="checkbox"/>
R:_____mm	Normal	<input type="checkbox"/>	<input type="checkbox"/>
L:_____mm	Long	<input type="checkbox"/>	<input type="checkbox"/>

		Left	Right
Ankle Dorsiflexion	Increased	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased	<input type="checkbox"/>	<input type="checkbox"/>
Knee position	Straight	<input type="checkbox"/>	<input type="checkbox"/>
	Genu Varum	<input type="checkbox"/>	<input type="checkbox"/>
	Genu Valgum	<input type="checkbox"/>	<input type="checkbox"/>
	Genu Recurvatum	<input type="checkbox"/>	<input type="checkbox"/>
Equinus	Absent	<input type="checkbox"/>	<input type="checkbox"/>
	Present	<input type="checkbox"/>	<input type="checkbox"/>
Gait Pattern:			
	<input type="checkbox"/> Straight		
	<input type="checkbox"/> Out-Toe		
	<input type="checkbox"/> In-Toe		
Has patient had orthotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, response was:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

800-732-5446

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