

NOTE TO PATIENT: PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

Patient Name: _____ DX: _____

Previous Treatments: _____

Treatment Considerations: _____

GAIT ANALYSIS *Lower extremity kinematics/kinetics*

TYPE _____ 3D 2D video 2D time-distance (GAITRite)

EMG (*see reverse for specifications*) Do Not Perform Perform dynamic EMG with gait analysis*

TRUNK _____ Perform Trunk Kinematics

FOOT PRESSURE _____ with 3D gait with 2D gait without gait analysis

O₂ CONSUMPTION* _____ with gait analysis without gait analysis

ORTHOTICS/ASSISTIVE _____ without with orthotics with assistive device(s)

UPPER EXTREMITY ANALYSIS*

SHUEE & EMG SHUEE & Kinematic SHUEE, EMG & Kinematic

* Indicates parent/patient must mention when making the appointment.

PLEASE SEE REVERSE ...▶

Referring Physician: _____

Fax: (_____) _____ Phone: (_____) _____

Address (to receive final report): _____

Street

City

State

Zip

**Please call
Computerized
Motion Analysis
312.238.1447
to schedule an appointment**

Computerized Motion Analysis

Surface Electromyography Conditions: *Please circle the muscles you would like monitored.
Up to 15 total muscles may be monitored at one time.*

LOWER EXTREMITY MUSCLES

Tibialis anterior	Gastrocnemius	Rectus femoris	Medial hamstrings
Adductor longus	Peroneus longus	Vastus medialis	Lateral hamstrings
Gluteus medius	Vastus lateralis	Gluteus maximus	

Other(s):

UPPER EXTREMITY MUSCLES

Biceps brachialis	Triceps	Brachioradialis	Flexor carpi ulnaris
Extensor carpi ulnaris			

Other(s):

NOTES OR SPECIAL REQUESTS