Date: _____

Clinic: _____

Patient Name: _____

☐ **Male** ☐ **Female** **Age**: _____ **Weight**: _____

Original Complaint: _____

Casting Method: ☐ **Impression Foam** ☐ **Slipper Cast** ☐ **Scan**

Adjusting: ☐ **Left** ☐ **Right** ☐ **Both**

ADJUSTMENT(S) TO BE COMPLETED

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***Please Complete all Fields**