

Milltown Physiotherapy Clinic Orthotic Satisfaction Questionnaire

Name: _____ Date of Birth _____

Address _____ Phone _____

_____ Date _____

1. Are you still wearing your orthotics?

All of the time

Some of the time Comment _____

Not at all Comment _____

2. Did your orthotics relieve your symptoms?

Completely

Somewhat Comment _____

Not at all Comment _____

3. What, if any problems did you encounter with your devices?

4. Considering my experience wearing orthotics, I would say I am

Satisfied

Unsatisfied