

ID _____
 Date _____
 Week _____

INSOLE WEAR DIARY

Day	Date	No. hours worn	Type of Shoes Worn e.g.. Joggers, Sandals, Court Shoes	Any skin damage or irritation e.g. blisters, redness? If yes please state location and any treatment received.		Any changes in sensation on the soles of the feet? If so where?		Any pain/discomfort when wearing insoles?		Comments
				Yes	No	Yes Area:	No	Yes	No	
MONDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
TUESDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
WEDNESDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
THURSDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
FRIDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
SATURDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	
SUNDAY				Yes Location: Specify Damage: Treatment:	No	Yes Area:	No	Yes	No	