FOOT/ANKLE QUESTIONNAIRE

Patient Name: ______________________________________ DOB: _____________ AGE: ________

1.) Which foot/ankle(s) did you hurt? ____

2.) Is this a new presentation of foot/ankle pain, or a follow-up? ____________________________

3.) Did another provider refer you? If yes, who? ____________________________________

4.) Describe how and where your symptoms occurred/how you injured your foot/ankle? Be Specific (include dates) ____

____

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5.) What best describes your foot/ankle pain? (check all that apply)

___aching ___grinding __gradual ___shooting ___worsening gradually
___ catching ___burning __improving ___stabbing ___worsening rapidly
___clicking ___cramp-like __pressure ___staying the same
___giving way ___diminishing __progressive ___swelling
___pins and needles ___dull __radiating ___tend to touch
___popping ___electric __sharp ___throbbing ___other________
___locking sensations ___shooting sensations __constant ___intermittent

6.) Describe the timing of your pain? (check all that apply)

____began today ___occurs episodically ___occurs randomly ___other________
___constantly occurs ___occurs in the morning ___occurs with activity ___occurs at night
___occurs intermittently ___occurs with weight bearing

7.) What is associated with your foot/ankle pain? (check all that apply)

____a cold foot __an ulceration __foot pain ___limited range of motion ___swelling
____a fracture ___bruising __knee pain ___numbness __low back pain ___other __________

8.) How severe is the pain on a scale of 0-10? (0 = no pain 10 = worst pain

Currently ___/10 on a bad day ___/10 on an average day ___/10
Initially ___/10 on a good day ___/10

9.) How long have you had your foot/ankle pain? ___years ___months __weeks __days

10.) Have you had any procedures or surgeries to treat the ankle/foot pain? If yes, what type?

____

______

11.) What are you currently using to treat the foot/ankle pain? (check all that apply)

___aspirin __narcotics/pain meds __topical cream __other___
___brace ____anti-inflammatory meds ___Tylenol
___exercise __muscle relaxants ____physical therapy __injections __rest, ice, and elevation
___no treatment

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12.) What diagnostic imaging studies have you had for this problem? (Check all that apply)

___bone scan ___MRI ___no imaging studies

___CT scan ___plain radiographs (X-ray) ___other______________________

13.) How has this problem limited you? (Check all that apply)

___attending school on a limited basis ___inability to work ____other ________________

___difficulty with ADL's ___requiring constant assistance

___difficulty with REC sports participation ___requiring occasional assistance

___difficulty with functional limitations ___working light duty

___difficulty getting up from a chair ___difficulty sitting ___difficulty standing

__difficulty walking ___inability attending school ___working on a limited basis

___inability to perform ADL's ___no limitations

14.) Who have you seen for this problem? (check all that apply)

___ER ___another Dr. ___therapist ___trainer ___urgent care ___walk-in clinic ___other________

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_______________________________ _______________________

Patient Name Date