

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) _____

- 5.) What best describes your foot/ankle pain? (check all that apply)
- | | | | | |
|---|--|--------------------------------------|---|--|
| <input type="checkbox"/> aching | <input type="checkbox"/> grinding | <input type="checkbox"/> gradual | <input type="checkbox"/> shooting | <input type="checkbox"/> worsening gradually |
| <input type="checkbox"/> catching | <input type="checkbox"/> burning | <input type="checkbox"/> improving | <input type="checkbox"/> stabbing | <input type="checkbox"/> worsening rapidly |
| <input type="checkbox"/> clicking | <input type="checkbox"/> cramp-like | <input type="checkbox"/> pressure | <input type="checkbox"/> staying the same | |
| <input type="checkbox"/> giving way | <input type="checkbox"/> diminishing | <input type="checkbox"/> progressive | <input type="checkbox"/> swelling | |
| <input type="checkbox"/> pins and needles | <input type="checkbox"/> dull | <input type="checkbox"/> radiating | <input type="checkbox"/> tend to touch | |
| <input type="checkbox"/> popping | <input type="checkbox"/> electric | <input type="checkbox"/> sharp | <input type="checkbox"/> throbbing | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> locking sensations | <input type="checkbox"/> shooting sensations | <input type="checkbox"/> constant | <input type="checkbox"/> intermittent | |

- 6.) Describe the timing of your pain? (check all that apply)
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> began today | <input type="checkbox"/> occurs episodically | <input type="checkbox"/> occurs randomly | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> constantly occurs | <input type="checkbox"/> occurs in the morning | <input type="checkbox"/> occurs with activity | <input type="checkbox"/> occurs at night |
| <input type="checkbox"/> occurs intermittently | <input type="checkbox"/> occurs with weight bearing | | |

- 7.) What is associated with your foot/ankle pain? (check all that apply)
- | | | | | | |
|--------------------------------------|--|------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> a cold foot | <input type="checkbox"/> an ulceration | <input type="checkbox"/> foot pain | <input type="checkbox"/> limited range of motion | <input type="checkbox"/> swelling | |
| <input type="checkbox"/> a fracture | <input type="checkbox"/> bruising | <input type="checkbox"/> knee pain | <input type="checkbox"/> numbness | <input type="checkbox"/> low back pain | <input type="checkbox"/> 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)
- | | | | | |
|---------------------------------------|---|---|--------------------------------------|---|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> narcotics/pain meds | <input type="checkbox"/> topical cream | <input type="checkbox"/> other _____ | |
| <input type="checkbox"/> brace | <input type="checkbox"/> anti-inflammatory meds | <input type="checkbox"/> Tylenol | | |
| <input type="checkbox"/> exercise | <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> physical therapy | <input type="checkbox"/> injections | <input type="checkbox"/> rest, ice, and elevation |
| <input type="checkbox"/> no treatment | | | | |

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

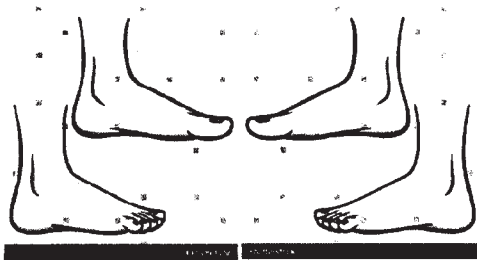
14.) Who have you seen for this problem? (check all that apply)

ER another Dr. therapist trainer urgent care walk-in clinic other _____

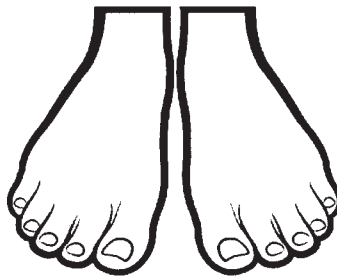
I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the 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



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