

# Ankle/Foot

Was this an injury or did it occur over time? \_\_\_\_\_

Date of injury or How long you have had this problem: \_\_\_\_\_

Which foot has the problem? Left / Right

Where do you have the problem? ankle / foot / heel / toes: 1(big) / 2 / 3 / 4 / 5

If an injury, describe how it occurred: \_\_\_\_\_  
\_\_\_\_\_

Have you had this or a similar problem before? Yes / No

If so, how was it treated? \_\_\_\_\_

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull
Constant burning	Come and go	Pins & Needles	
Explosive	Unrelenting	Throbbing	Electric
Constant	Intermittent	Chronic	
Getting better	Getting worse	Unchanged	
Worse in morning	Worse in evening	Worse at night	

What makes your pain **worse**? \_\_\_\_\_

What makes your pain **better**? \_\_\_\_\_

Medications used for this problem: \_\_\_\_\_

Have you had any tests for this problem: MRI / Bone Scan / X-Ray / Other: \_\_\_\_\_

Do you have numbness or tingling? Yes / No Where? \_\_\_\_\_

Do you have swelling? Yes / No Where? \_\_\_\_\_

Have you had any surgery on this area? Yes / No

Please list: \_\_\_\_\_

Do you have any other problems not previously described? Yes / No

Please describe: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Other Physician you have seen for this problem: \_\_\_\_\_

Dates of work/school missed for this problem: \_\_\_\_\_

Is there an attorney involved with this problem? If yes, please provide additional information.

\_\_\_\_\_

Name \_\_\_\_\_

Date: \_\_\_\_\_

