

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

My current problem is: \_\_\_\_\_

**Symptoms**

▪ **Select Pain Location & Side** (x in box)

**Ankle** -       Right  Left  Both:

**Heel** -       Right  Left  Both:

**Arch / Midfoot** -  Right  Left  Both:

**Great toe** -       Right  Left  Both:

**Lesser toes** -  Right  Left  Both:

▪ **Associated Symptoms:** (select all that apply)

**Deformity**       Right  Left  Both

**Giving Way**     Right  Left  Both

**Stiffness**       Right  Left  Both

**Swelling**       Right  Left  Both

**Locking**         Right  Left  Both

**Ulcer/wound**    Right  Left  Both

▪ **Duration** – When did this start? (How long has it bothered you?) \_\_\_\_\_

Injury? (Date of injury) \_\_\_\_\_

Work injury     Car accident     Motorcycle     Sports

Describe: \_\_\_\_\_

▪ **Context**      In general, my problem is getting:     Better     Worse     Staying the same

▪ **Severity (0-10, 0 = no pain, 10 = worst pain possible)**

At its Worst, my pain is: (R) \_\_\_\_/10 (L) \_\_\_\_/10

On Average, my pain is: (R) \_\_\_\_/10 (L) \_\_\_\_/10

▪ **Character**     Sharp     Stabbing     Ache     Sore     Burning/tingling     Shooting

▪ **Timing**       Morning     End of Day     Night     Walking/standing     Stairs  
 Prolonged sitting     Running     Exercise \_\_\_\_\_     All of the time

▪ **Alleviating Factors (Things that make it better)** \_\_\_\_\_

▪ **Aggravating Factors (Things that make it worse)** \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Prior Treatment** (select all that apply)

- Medications \_\_\_\_\_
- Rest  Brace  Boot  Cast  Orthotic / arch support  Toe spacer / padding / taping
- Cane / Crutch  Walker  Physical therapy – how long? \_\_\_\_\_
- Injection(s) – how many? \_\_\_\_\_

Please list interventions that you believe were helpful (include in ( ) what % you think they helped):  
For example: Bracing (30%) \_\_\_\_\_

\_\_\_\_\_

Surgery – (Please list date, procedure, surgeon, facility and city where the surgery was performed)

\_\_\_\_\_

\_\_\_\_\_

Other Treatments \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please select YES or NO to indicate if you CURRENTLY have any problems in one or more of the following areas. If yes, please explain or describe the problem.

GENERAL/CONSTITUTIONAL  Yes  No \_\_\_\_\_  
(fever, weight loss or gain, tired feeling)

EYES  Yes  No \_\_\_\_\_  
(blurred vision, eye pain, discharge, etc)

EARS, NOSE, THROAT, MOUTH  Yes  No \_\_\_\_\_  
(hearing loss, ear ache, nasal congestion, cough, nasal drip, dry mouth, etc)

RESPIRATORY  Yes  No \_\_\_\_\_  
(wheezing, shortness of breath, snoring)

CARDIOVASCULAR  Yes  No \_\_\_\_\_  
(chest pain, difficulty sleeping fully reclined)

GASTROINTESTINAL  Yes  No \_\_\_\_\_  
(diarrhea, constipation, hernia, ulcers, etc)

GENITOURINARY  Yes  No \_\_\_\_\_  
(painful urination, frequent urination, impotence, jaundice, etc)

HEMATOLOGIC / LYMPHATIC  Yes  No \_\_\_\_\_  
(anemia, bleeding problems, problems with blood transfusions, etc)

MUSCULOSKELETAL  Yes  No \_\_\_\_\_  
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling, etc)

SKIN  Yes  No \_\_\_\_\_  
(rash, burn, infection, etc)