

LEG QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):																		
1	WHICH LEG IS BOTHERING YOU?							RIGHT	LEFT									
2	ON A SCALE OF 0-10 (10 IS THE WORST) HOW SEVERE IS YOUR PAIN?							0	1	2	3	4	5	6	7	8	9	10
3	WHAT KIND OF PAIN ARE YOU HAVING?																	
	YES	NO	SHARP				YES	NO	THROBBING									
	YES	NO	DULL				YES	NO	ACHING									
	YES	NO	STABBING				YES	NO	BURNING									
4	DO YOU HAVE?																	
	YES	NO	NUMBNESS				YES	NO	SWELLING									
	YES	NO	TINGLING				YES	NO	LOCKING/CATCHING									
	YES	NO	WEAKNESS				YES	NO	GIVING WAY									
5	THE PAIN IS NOW?					6	DOES YOUR PAIN?											
	YES	NO	CONSTANT				YES	NO	WAKE YOU FROM YOUR SLEEP									
	YES	NO	COMES AND GOES				YES	NO	KEEP YOU FROM SLEEPING									
7	YES	NO	DO YOU LIMP?															
8	SINCE MY PROBLEM STARTED , IT IS?																	
	BETTER		WORSE			UNCHANGED												
9	WHAT MAKES YOUR SYMPTOMS WORSE?																	
	STANDING		WALKING		LYING IN BED		EXERCISE		TWISTING		SQUATTING							
	LIFTING		KNEELING		STAIRS		SITTING		Other									
10	WHAT MAKES YOUR SYMPTOMS BETTER?																	
	REST		ICE		HEAT		ELEVATION		Other									
11	YES	NO	HAVE YOU INJURED THIS LEG BEFORE?															
	IF YES, WHEN?																	
12	YES	NO	HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM?															
	IF YES, USE CHECK BOXES BELOW TO DESCRIBE TREATMENTS:																	
	TREATMENT					DID IT HELP?		TREATMENT			DID IT HELP?							
	ANTI-INFLAMMATORIES					YES	NO	INJECTION			YES	NO						
	CANE/CRUTCHES					YES	NO	SURGERY			YES	NO						
	PHYSICAL/OCCUPATIONAL THERAPY					YES	NO	NARCOTICS			YES	NO						
	HOME EXERCISE PROGRAM					YES	NO	BRACE/CAST			YES	NO						
13	IF YOU HAVE HAD SURGERY ON YOUR LEG BEFORE, WHEN DID YOU HAVE IT?																	
14	YES	NO	WERE YOU SEEN IN THE EMERGENCY ROOM FOR THIS PROBLEM?															
	IF YES, WHICH EMERGENCY ROOM?																	
15	WHAT TESTS HAVE YOU HAD FOR THIS PROBLEM?																	
16	IF YOU HAVE HAD X-RAYS OR AN MRI, WHERE WERE THEY TAKEN?																	

