ANKLE QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which ankle(s) did you hurt? _____

2.) Is this a new presentation of 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 ankle? Be specific (include **dates**)

_____

_____

5.) 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

6.) What best describes your ankle pain? (check all that apply)

__aching __pins and needles __burning __improving __worsening gradually
__catching __popping __constant __intermittent __worsening rapidly
__clicking __pressure __cramp-like __radiating other:_____
__giving way __shooting sensations __diminishing __sharp
__grinding __swelling __dull __stabbing
__locking sensations __throbbing __electric __tender to touch

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

__a cold foot __an ulceration __foot pain __limited range of motion __numbness other:_____
__a fracture __bruising __knee pain __low back pain __swelling

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 ankle pain? ___years ___months ___weeks ___days

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

__aspirin __muscle relaxants __rest, ice, and elevation
__brace __narcotics/pain meds __topical cream
__exercise __anti-inflammatory meds __Tylenol
__injections __physical therapy other:_____

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

_____

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
__difficulty attending school
__difficulty getting up from a chair
__difficulty sitting
__difficulty standing
__difficulty walking
__difficulty with ADL's
__difficulty with REC sports participation
__difficulty with functional limitations
__inability to perform ADL's
__inability to work requiring constant assistance
__requiring constant assistance
__requiring occasional assistance
__working light duty
__working on a limited basis
__no limitations
other:_____

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

__ER __another doctor __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 acurately 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 payors and/or health practicioners. 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's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

1			
2			
3			
4			
5			
6			
7			