FOOT QUESTIONNAIRE

Patient Name: ____ DOB: ___________________________

1.) Which foot(s) did you hurt? ____

2.) Is this a new presentation of foot pain, or a follow-up?____

3.) Did another provider refer you? If yes, who?____

4.) Describe **how** and **where** your symptoms occurred/how did your foot pain begin? Be specific (include **dates**)

____

____

5.) What is the quality of your pain/what best describes your foot pain? (check all that apply)

__aching __grinding __gradual __shooting __worsening
__catching __burning __improving __stabbing other:____________
__clicking __cramp-like __prssure __staying the same
__giving way __diminishing __progressive __swelling
__pins and needles __dull __radiating __tender to touch
__popping __electric __sharp __throbbing

6.) Describe the timing of your pain? (check all that apply)

__acute __intermittent __worse during activity other:______________
__acute on chronic __random __worse during the day
__chronic __variable __worse during the night
__episodic __worse at the end of the day __worse in the morning

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

__a cold foot __ankle pain __limited range of motion __swelling
__a flat foot __bruising __numbness 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 pain? ___years ___months ___weeks ___days

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

____

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

__activity modification __narcotics/pain meds __topical cream other:________________
__brace __anti-inflammatory meds __Tylenol
__custom orthotic __physical therapy __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
__difficulty with ADL's
__difficulty with REC sports participation
__functional limitations
__inability attending school
__inability to perform ADL's
__inability to work
__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	______________________	______________________	__________