LEG QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which leg(s) did you hurt? _____
2.) Is this a new presentation of leg 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 leg? Be specific (include **dates**)

_____

_____

5.) What best describes your leg pain? (check all that apply)

__aching __diminishing __intermittent __radiating to knee __throbbing
__acute __dull __pins and needles __radiating to toes __worsening
__burning __electric __popping __sharp other:_____
__catching __giving way __pressure __stabbing
__clicking __gradual __progressive __staying the same
__constant __grinding __radiating __swelling
__cramp-like __improving __radiating to foot __tender to touch

6.) What is associated with your leg pain? (check all that apply)

__ankle stiffness __foot numbness __leg swelling __limping
__bruising __foot swelling __limited ROM of ankle other:_____
__cramping __knee stiffness __limited ROM of foot

7.) 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

8.) What aggravates or alleviates your pain? (check all that apply)

__improves with elevation __worsens with dependent positioning __worsens with walking
__improves with rest __worsens with jumping other:_____
__improves with stretching __worsens with standing

9.) 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

10.) How long have you had your leg pain? ___years ___months ___weeks ___days

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

__accupuncture __massage therapy __splint
__activity modification __muscle relaxants __topical cream
__brace __narcotics/pain meds __Tylenol
__compression stockings __anti-inflammatory meds __no treatment
__lidocaine patches __physical therapy other:_____

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

_____

13.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__CT scan __plain radiographs (X-ray) other:_____

__MRI __no imaging studies

14.) How has this problem limited you? (check all that apply)

__attending school on a limited basis
__difficulty getting up from a chair
__difficulty sitting
__difficulty standing
__difficulty walking
__difficulty with ADL's
__difficulty with REC sports participation
__functional limitations
__inability to go to 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:_____

15.) 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	_____	_____	_____