

Name: _____

1. What is the main issue that brought you in today (check all that are appropriate):

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Second opinion | <input type="checkbox"/> Uncomfortable shoe wear |
| <input type="checkbox"/> Instability | <input type="checkbox"/> Deformity | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Failed surgery | <input type="checkbox"/> Bunion | <input type="checkbox"/> Recent Injury |

2. How long as the current problem been going on?

3. Which side is involved? Right Left Both

If pain is the concern, please use an arrow to indicate the area on the diagram that hurts the most . If more than one area of pain exists, please rank the sites from most to least painful (ie #1, #2, etc). If both sides are involved label the areas L (left) and R (right)



4. On a scale of 0 to 10 what is the level of pain? _____

5. Does this affect you mainly while: standing sitting both

6. Is the problem: improving worsening staying the same

7. Does this problem occur: with shoes without shoes both

8. What % of sitting _____ and standing _____ do you have at work?

9. What activity are you unable to enjoy as a result of this condition?

10. Circle the treatments that you have tried until this point?

- | | | |
|--|---|--|
| <input type="checkbox"/> Brace | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Change of Job |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Prolotherapy | <input type="checkbox"/> New shoes |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Massage | <input type="checkbox"/> Elevation |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Orthotic | |

Age _____ Ht _____ Wt _____ Pulse _____ Reg / Irreg

UPPER EXTREMITIES: Normal / (Hyperlaxity Y N)

STANDING: Arch (Flat / Normal / High) Hindfoot (Varus / Neutral / Valgus)

GAIT: Normal / Antalgic (L R) / Slow / Unable

SINGLE HEEL RAISE: Normal / Painful (L R) / Unable (L R)

ROM: R (A / H / TT / MTP /)
L (A / H / TT / MTP /)

ANKLE STABILITY: Drawer R ___ L ___ Passive Inv R ___ L ___

SKIN:

PALPATION: Right _____ Left _____

Hindfoot -

Midfoot -

Forefoot -

SENSORY: DPN/SPN/Sur/Saph/Tib

MOTOR: TA/EDL/PTT/FDL/ FHL/PL/PB/GS

PULSE: ___ + DP, ___ +PT

XRAY: Ankle -

PMHx: DM/RA/PVD

PSHx:

Meds:

Foot -

All:

Dx:

Soc: Smoke / Alc / Drugs

Plan:

DME: