

Name: _____ Date of Birth: _____

Foot and Ankle Intake Form

Subjective _____

When did your problem start? _____

How often do you have pain? Constant Many times every day Many times every week Other _____

Night pain? Yes No

Any other symptoms? Please check all that apply: Numbness Tingling Pins and needles

What makes the problem worse?

What makes the problem better?

What diagnostic studies have been done? Please circle and date the study

CT scan: _____

Xray: _____

MRI: _____

Bone scan: _____

Vascular Studies: _____

Other: _____

Which pain medications have you taken for this problem? Please check all that apply

Naproxen (Alleve): _____ number of pills per day Vicodin: _____ number of pills per day

Ibuprofen (Advil, Motrin): _____ number of pills per day Oxycodone /Oxycontin: _____ number of pills per day

Celebrex: _____ number of pills per day Other _____: _____ number of pills per day

Have you participated in physical therapy? _____ number of months

Have you modified your shoes? Yes No Was it helpful? Yes No

Have you used orthotics or any other inserts in your shoes? Yes No For how long? _____

Have you had injections? Yes No Number of injections: _____

How much did it help on the day of the injection? None A little 50% A lot Completely

For how long did it help? _____ number of days / months (please circle)

Any other treatments? Please list:

