THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

ORTHO FOOT & ANKLE

For Office Use Only: Provider #_____
MRN #_____ Staff Initials _____

Appointment Date: ____/____/____ Name: _____

Date of Birth: ____/____/____ Age: _____ Primary Care Physician: _____

Who referred you today? ❑ Self ❑ Friend ❑ Provider What is your approximate shoe size? _____

PLEASE CHECK YES OR NO IF YOU ARE FREQUENTLY BOTHERED BY, OR HAVE BEEN TREATED BY A DOCTOR FOR:

Bleed Easily	Yes ❑ No ❑	Taking Blood Thinners	Yes ❑ No ❑	Surgical Complications	Yes ❑ No ❑
Blood Clots	Yes ❑ No ❑	Difficulty with Anesthesia	Yes ❑ No ❑	H/O Infection	Yes ❑ No ❑
Skin Wound	Yes ❑ No ❑				

What **problem** would you like us to address today? ❑ Right Foot ❑ Left Foot ❑ Right Ankle ❑ Left Ankle

_____

Is this problem because of an **injury**? ❑ Yes ❑ No If yes, ❑ Motor Vehicle Accident ❑ Work ❑ Sports ❑ Other _____

Describe Injury _____

_____

When did the injury occur? _____ Is there a work claim? ❑ Yes ❑ No

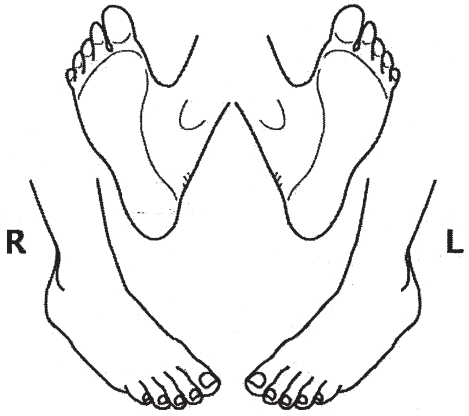
If yes, what if the actual date of injury? _____

Vocation _____

Employer _____

Attorney _____

If you have **pain**, please locate and rate your **pain** on the diagrams to the right.



Rate your current level of pain. Please circle the number that applies to your pain level.

Least 1 2 3 4 5 6 7 8 9 10 Worst

How long have you had pain / discomfort? ❑ Days ❑ Weeks ❑ Months ❑ Years

Please **describe** your pain: ❑ Sharp ❑ Stabbing ❑ Burning ❑ Pins/Needles ❑ Pressure ❑ Throbbing ❑ Radiating ❑ Ache/Deep ❑ Dull

When do you feel pain: ❑ Morning ❑ Work/Activity ❑ Uneven Ground ❑ Sports ❑ Startup ❑ Evening ❑ Night

What **improves** or **worsens** your pain? _____

_____

_____

Have you tried any of the following to treat your pain?		Did it help?
Ice	Yes ❑ No ❑	Yes ❑ No ❑
Exercise	Yes ❑ No ❑	Yes ❑ No ❑
Physical Therapy	Yes ❑ No ❑	Yes ❑ No ❑
Previous Injections	Yes ❑ No ❑	Yes ❑ No ❑
Heat	Yes ❑ No ❑	Yes ❑ No ❑
Rest	Yes ❑ No ❑	Yes ❑ No ❑
Medication	Yes ❑ No ❑	Yes ❑ No ❑