Do not write, stamp, punch holes or affix a sticker in this area.

To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Foot / Ankle

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

AGE

AFFECTED SIDE

	left	right	both
foot	○	○	○
ankle	○	○	○
toes	○	○	○

ONSET OF SYMPTOMS

Which best describes how your symptoms began?

○ due to an injury ○ gradual onset ○ sudden onset

How long ago did the symptoms begin?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ >10 ○

○ days ago ○ weeks ago ○ months ago ○ years ago

If you do not remember when your symptoms began, please describe how long you have been experiencing the symptoms:

Over the last: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16+ ○

○ weeks ○ months ○ years

TIMING

○ constant ○ intermittent ○ occasional

○ rare ○ daytime ○ nighttime

○ pain causes me to wake up from sleep

other: _____

HOW DID YOUR PROBLEM START?

○ at home ○ at work ○ during athletic activities

○ non-vehicle accident ○ motor vehicle accident ○ no known cause

other: _____ _____

If you have had multiple injuries, please describe: _____

MECHANISM

○ pulling ○ twisting ○ lifting ○ bending

○ direct blow ○ fall ○ sleep position ○ repetitive motion

○ reaching

other: _____ _____

PAIN

Are you currently experiencing pain? ○ yes ○ no

How much pain are you experiencing... **0 = no pain** **10 = intolerable**

NOW: ☺ No Pain 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ ☹ Intolerable

AT ITS WORST: ☺ No Pain 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ ☹ Intolerable

QUALITY

○ sharp ○ dull ○ aching

○ burning ○ stabbing ○ throbbing

○ stinging

other: _____

ASSOCIATED SIGNS AND SYMPTOMS

○ stiffness ○ weakness ○ locking

○ catching ○ numbness ○ tingling

○ giving way

other: _____

For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***

PROGRESSION

- ◯ worsening
- ◯ improving
- ◯ resolved
- ◯ unchanged

other: _____

WHAT MAKES YOUR PAIN WORSE?

- ◯ **nothing makes the pain worse**
- ◯ lying down
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ climbing stairs
- ◯ getting out of a chair
- ◯ bending forward
- ◯ bending backward
- ◯ coughing
- ◯ sneezing

other: _____ _____

WHAT MAKES YOUR PAIN BETTER?

- ◯ **nothing makes the pain better**
- ◯ ice
- ◯ heat
- ◯ rest
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ lying down
- ◯ using a brace
- ◯ using a splint
- ◯ using crutches
- ◯ elevation
- ◯ stretching
- ◯ prescription medication
- ◯ over-the-counter medication
- ◯ changing activities
- ◯ massage
- ◯ physical therapy
- ◯ injections
- ◯ chiropractor
- ◯ previous surgery
- ◯ medications

other: _____

TREATMENT HISTORY

Have you gone to any other locations for today's problem?

- ◯ **none**
- ◯ Urgent Care
- ◯ Emergency Room
- ◯ Chiropractor
- ◯ Inpatient Evaluation
- ◯ Primary Care Provider
- ◯ Other Ortho Physician
- ◯ Other Physician at this Location

other: _____

Have you had any of the following for today's problem?

- ◯ X-Ray
- ◯ CT Scan
- ◯ MRI

other: _____

WORK HISTORY

Are you currently working?

- ◯ no (If no, when did you last work?): _____
- ◯ yes
- ◯ disabled
- ◯ retired

Are you currently on any work restrictions?

- ◯ no
- ◯ yes (please explain): _____

Occupation: _____ **Employer:** _____

CURRENT SYMPTOMS

Please mark all symptoms you are <u>CURRENTLY</u> experiencing.
Mark all that apply. If no symptoms in a category, please mark "NONE."

GENERAL	◯ trouble sleeping ◯ recent weight loss	◯ fatigue ◯ loss of appetite	◯ **NONE**
CARDIOVASCULAR	◯ chest pain	◯ palpitations	◯ **NONE**
SKIN	◯ frequent rashes ◯ skin ulcers	◯ lumps ◯ non-healing wound	◯ **NONE**
EAR / NOSE / THROAT	◯ hearing loss	◯ hoarseness ◯ trouble swallowing	◯ **NONE**
ENDOCRINE	◯ cold intolerance	◯ heat intolerance	◯ **NONE**
EYES	◯ vision loss	◯ blurred vision ◯ double vision	◯ **NONE**
GASTROINTESTINAL	◯ heartburn ◯ nausea	◯ vomiting ◯ blood in stool	◯ **NONE**
GENITOURINARY	◯ blood in urine	◯ painful urination	◯ **NONE**
HEMATOLOGIC / LYMPHATIC	◯ easy bruising	◯ easy bleeding	◯ **NONE**
NEUROLOGICAL	◯ headaches	◯ dizziness ◯ numbness	◯ **NONE**
PSYCHIATRIC	◯ feeling anxious	◯ feeling depressed	◯ **NONE**
RESPIRATORY	◯ chronic cough	◯ shortness of breath	◯ **NONE**