

ANKLE & FOOT PAIN ANALYSIS SURVEY

Name: _____

Phone: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- | | |
|---|---|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain in feet getting out of bed |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> "Toe-in" or "Toe-out" gait (walking) |
| <input type="checkbox"/> Heel or Arch Pain | <input type="checkbox"/> Pain or fatigue of feet or legs in activity |
| <input type="checkbox"/> Leg pain (shin splints) | <input type="checkbox"/> Ankle instability (easy twisting injuries) |
| <input type="checkbox"/> Achilles tendon pain | <input type="checkbox"/> Difficulty / Pain with brisk walking or running |
| <input type="checkbox"/> Discoloration of toes /foot | <input type="checkbox"/> Pain legs occurs at the same distance every time |
| <input type="checkbox"/> Ankle swelling or stiffness | <input type="checkbox"/> Coldness in the legs or feet that is uncomfortable |
| <input type="checkbox"/> Pain in feet or legs with exercise | <input type="checkbox"/> Poor or non-healing sore on the leg or foot |
| <input type="checkbox"/> Foot/Toes/Legs Burn | <input type="checkbox"/> Feet/Toes feel numb |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain |

Please answer the following about the above conditions:

Is this condition causing or are you suffering with any of the following: (R –right; L – left)

- | | | | |
|------------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| Tingling/Numbness in: | Pain radiating into: | Weakness of the: | Difficulty with: |
| <input type="checkbox"/> Legs R/L | <input type="checkbox"/> Ankle R/L | <input type="checkbox"/> Legs R/L | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Ankle R/L | <input type="checkbox"/> Feet R/L | <input type="checkbox"/> Ankle R/L | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Feet R/L | <input type="checkbox"/> Toes R/L | <input type="checkbox"/> Foot R/L | <input type="checkbox"/> Sitting |
| | | | <input type="checkbox"/> Bending |
| | | | <input type="checkbox"/> Lifting |
| | | | <input type="checkbox"/> Kneeling |

How long have you been suffering with this condition?
Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes No

Would you like to get rid of or reduce this problem? Yes No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today:

- I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.
- If it were available, I would be interested in receiving treatment for this condition in the office.
- If available, I would be open to have a medical test to further evaluate my problem.

Date

Patient Signature