SARASOTA FOOT AND ANKLE CENTER

FOOT PAIN FORM

Patient Name: _____ **Date of birth**_____

Do you have FOOT PAIN? ☐YES ☐NO ☐RIGHT ☐LEFT ☐BOTH
If YES, please describe: _____
On scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____
The pain quality is ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling
For how long? _____, previous treatment for this pain/problem? ☐YES ☐NO
If YES, please describe: _____
Does anything make it: ☐better ☐worst?

Do you have any KNEE PAIN? ☐YES ☐NO ☐RIGHT ☐LEFT ☐BOTH
If YES, please describe: _____
For how long? _____, previous treatment for this pain/problem? ☐YES ☐NO
If YES, please describe: _____
Does anything make it: ☐better ☐worst?

Do you have any HIP PAIN? ☐YES ☐NO ☐RIGHT ☐LEFT ☐BOTH
If YES, please describe: _____
For how long? _____, previous treatment for this pain/problem? ☐YES ☐NO
If YES, please describe: _____
Does anything make it: ☐better ☐worst?

Do you have any BACK PAIN? ☐YES ☐NO
If YES, please describe: _____
For how long? _____, previous treatment for this pain/problem? ☐YES ☐NO
If YES, please describe: _____
Does anything make it: ☐better ☐worst?

Do you have any LEG CRAMPS OR PAIN? ☐YES ☐NO ☐RIGHT ☐LEFT ☐BOTH
If YES, please describe: _____
For how long? _____, previous treatment for this pain/problem? ☐YES ☐NO
If YES, please describe: _____
Does anything make it: ☐better ☐worst?

Do any of the above problem limit your ability?
to walk ☐YES ☐NO
to stand ☐YES ☐NO
to wear shoes ☐YES ☐NO
to work ☐YES ☐NO
to partake in social or sporting activities? ☐YES ☐NO

Do you currently wear or have you ever worn Orthotics (arch supports?) ☐YES ☐NO
If YES, were they prescribed to you by a physician or Healthcare provider? ☐YES ☐NO
if YES, were they the over the counter style bought from a store? ☐YES ☐NO
If YES, did you find that they helped you to any significant degree? ☐YES ☐NO

If you're a runner or athlete, please tell us about your sport, include recent history, weekly mileage breakdown, frequency or times and if you are currently training for any event.

What type of shoes do you wear and how often do you wear them? *(Please check or cross out)*

	MALE	% OF TIME		FEMALE	%OF TIME
	Sneakers/ tennis shoes	%		Sneakers/ tennis shoes	%
	Lace up dress shoes	%		Casual shoes	%
	Loafers or deck shoes	%		Pump or low heel open shoes	%
	Works boots or other boots	%		High heel shoe (2inch or greater)	%
	Flip flops or sandals	%		Work boots or other boots	%
				Flip flops or sandals	%

When you're at home, what is on your feet?

	Regular shoes	%
	Slippers	%
	Bare foot	%

THIS IS THE MOST IMPORTANT PART OF THIS PAPER WORK

In the few months has there been a recent changes in your

☐ Weight ☐ work ☐ activity ☐ shoe gear ☐ flooring at work or home

Please describe: _____

What are your goals & expectations relating to your problem?

Relating to your specific complaint(s), what would you like to accomplish DURING YOUR VISIT TODAY?

Relating to your specific complaint(s), what would you like to accomplish IN THE NEAR FUTURE that you may not be able to do right at this moment? *(Please include intermediate & long term goals)*

I understand that any follow up appointments I make are crucial to my treatment and the success of my care, during these appointments, the doctor will give you the necessary attention. Please have the courtesy of keeping all appointments or calling to change an appointment with 24 hours' notice.

I understand that I WILL BE CHARGED a fee of $40.00, for any appointments missed with less than 24 hours cancellation.

_____ _____

PRINTED NAME DATE