Name: ______________________ **Today's Date:** ______________

Please shade in the location and type of pain you are having.

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Dull / Aching	Burning	Sharp	Numbness / Tingling

Circle

Left Foot
or
Right Foot

Please circle things which make your pain worse and ✓ check the things which make the pain better.

- ☐ Tight Shoes
- ☐ Walking
- ☐ Rest
- ☐ Anti-inflammatory Medicines
- ☐ Night
- ☐ High Heels
- ☐ Running
- ☐ Hardwood Floors
- ☐ Massage
- ☐ Ice
- ☐ Standing

How long have you had this problem? ______________________

Any history of foot problems in the family? ______________________

My pain discomfort level is: (circle number) 0 1 2 3 4 5 6 7 8 9 10

Name of primary Care Physician (PCP) ______________________

Date of last visit with PCP: Month: ____________ Year: ____________

Name: ______________________ **Today's Date:** ______________

I consider the pain in any foot or ankle as: (choose one):

None__________ Mild, occasional__________

Moderate, daily__________ Severe, almost always present__________________

I have trouble with everyday activities because of my foot or ankle : Yes ☐ No ☐

I have trouble with recreational activities because of my foot or ankle : Yes ☐ No ☐

I currently use a cane: --- Yes ☐ No ☐

I currently use crutches, walker or wheelchair: -- Yes ☐ No ☐

How many city blocks can you walk?
6 or more_____; 4 - 6_____; 1 - 3_____; Less than 1_____

Choose One:

- ☐ I do not have difficulty walking on any surface.
- ☐ I have some difficulty on uneven terrain, stairs, inclines or ladders.
- ☐ I have severe difficulty on uneven terrain, stairs, inclines or ladders.

Choose One:

- ☐ I am able to wear fashionable or conventional shoes.
- ☐ I am only able to wear comfortable shoes.
- ☐ I currently wear a modified shoe or brace.

I currently wear a shoe insert: -- Yes ☐ No ☐