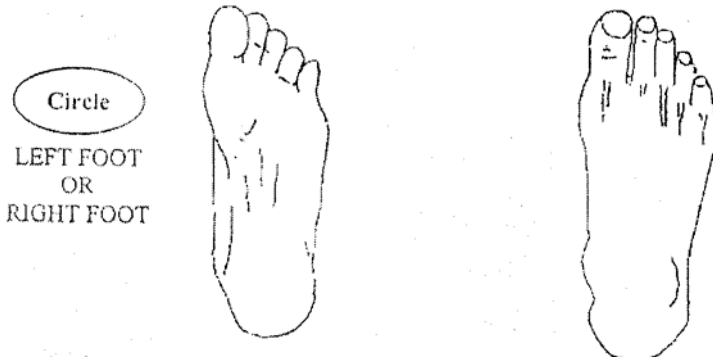
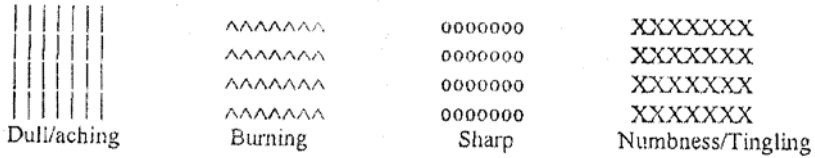


Michael Werner M.D.

Name: _____ **Today's Date:** _____

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



Circle
LEFT FOOT
OR
RIGHT FOOT

Please circle the 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 | Massage | Hardwood Floors | Standing | Ice | |

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_____