



Foot and Ankle New Patient Form

Name: _____ DOB: _____ Date of Exam: _____

Male/Female Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____ Hobbies/Goals: _____

What specific foot or ankle concern would you like addressed today? (Ex: Right heel pain) or (Left Big Toe pain)

When did you condition begin? _____ Injury related: Y / N

If so, what type of injury? _____ Where did it happen? _____

What bothers you most about your foot or ankle? Pain Swelling Feels Unstable Deformity

What distance can you walk before your symptoms begin?

Unlimited 4-6 blocks 1-3 blocks Less than 1 block

Mark the scale with a vertical line to indicate your *average* pain due to your foot and ankle condition.



Which activities make your symptoms worse? Uneven Ground Other _____
 Walking Running First steps in AM Certain Shoes Getting up from sitting

Which of the following treatments have you tried?

Anti-Inflammatory Medications Physical Therapy Shoe Modifications Inserts
 Cortisone Injections Bracing Casting Walker Boot Surgery

List any diagnostic studies you've had for this condition and the date they were done. (MRI, CT, Bone Scan, EMG)

1. _____ 3. _____
2. _____ 4. _____

Have you had any surgery on your feet or ankles? Y / N

Please list them below.

1. _____ 3. _____
2. _____ 4. _____

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