ORTHOPEDIC ASSOCIATES of Northern California

Todays Date:_____

ANKLE/FOOT

NAME_____ **REFERRED BY?**_____

Which ankle/foot are we seeing you for today (please circle)? Right Left Both
Occupation:_____ Are you currently working: _____
Do you feel your injury is work related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

How was your ankle/foot injured (Include date, if any, and how long you have had a problem)?

_____
_____
_____

PAIN
Where in the ankle/foot does it hurt:_____
Frequency of pain: Constant Intermittent
Pain Scale (circle one): 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe
Aggravating activities (please circle):
Stairs (up/down) uneven ground pain at night running
pain with weight bearing prolonged standing/walking
Other:_____

Walking Aid used: None Cane Crutches Walker Wheelchair Motorized Scooter

Giving out or dislocations Yes No

Swelling Yes No

Loss of Motion Yes No

Prior ankle/foot Problems Yes No

Prior ankle/foot Surgery Yes No

Treatment Received for current condition
Medications _____
Injections _____
Physical Therapy (How many sessions) _____
Surgery _____
Other Physicians _____
Chiropractic _____
Ankle Braces _____
Other _____