Name:

DOB:

Date:

OrthoCincy

## Foot and Ankle Evaluation

Referring Physician: _____ Primary Care Physician: _____

Problem is: Right Left Both Problem is: New Injury Long Term Problem

Describe how it happened: _____

Describe where you were:

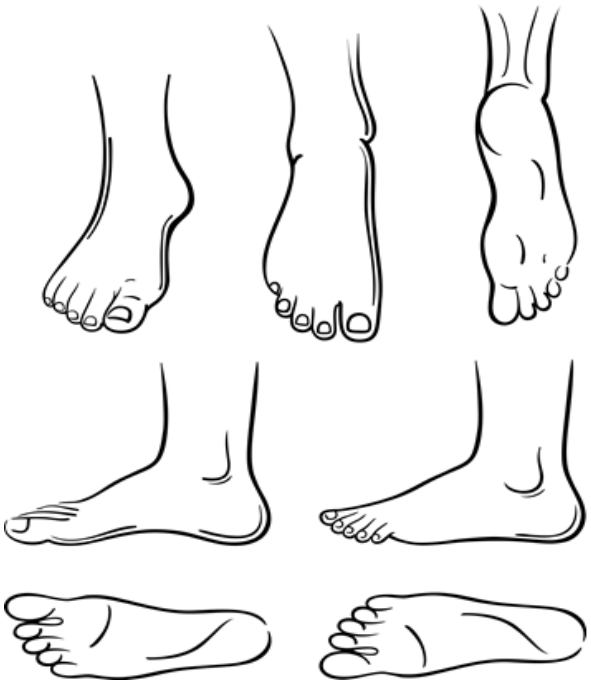
_____

- ☐ **No specific injury**
- ☐ Fall
- ☐ Sports Injury
- ☐ Work related
- ☐ Auto Accident

The date the symptoms began: _____

- ☐ ____ Weeks ago
- ☐ ____ Months ago
- ☐ ____ Years ago

On this diagram mark where your pain is:



Check what **BEST** applies:

The pain is:
- ☐ RARE
- ☐ INTERMITTENT
- ☐ CONSTANT

The pain is:
- ☐ DULL
- ☐ SHARP
- ☐ ACHY
- ☐ BURNING

Check **ALL** that apply:
- ☐ CATCHING/LOCKING
- ☐ POPPING
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ WEAKNESS
- ☐ GIVES OUT
- ☐ SWELLING
- ☐ BURNING

| **What is your pain scale:** | 0 1 2 3 4 5 6 7 8 9 10 |
|---|---|
| | 0 = no pain 10 = worst pain |

### Testing

- ☐ **NONE**
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Nerve Test (EMG/NCS)
- ☐ Lab/Blood work
- ☐ Other: _____

_____

_____

### Treatment

- ☐ **NONE**
- ☐ Medications:
  - *Anti-Inflammatories*
  - *Pain Meds*
  - *Antibiotics*
- ☐ Injections
- ☐ Splints / Braces
- ☐ Physical / Hand Therapy
- ☐ Surgery _____
- ☐ Other: _____

### Where

- ☐ ER (St. Elizabeth / other)
- ☐ COC After Hours Injury Clinic
- ☐ Urgent Care
- ☐ St. E Business Health/Concentra
- ☐ Family PCP
- ☐ Orthopaedic Surgeon _____
- ☐ Podiatrist _____
- ☐ Specialist _____
- ☐ Other: _____

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**General Screening:**

| | | |
|---|---|---|
| Have you injured this area in the past? | Yes | No |
| Do your feet or legs burn or tingle? | Yes | No |
| Do your feet or legs swell? | Yes | No |

**What do you hope to gain from this visit? (Circle all that apply)**

Understanding of my condition

Education about my condition

Fix the problem

Surgery if that is what is required to fix the problem

Surgery as a last resort

Avoid surgery at all costs

**Worker's Comp Injury Information**

Employer: _____

How long have you worked there? _____

Are you working now?

- ☐ No, last date worked: _____
- ☐ Yes, light duty
- ☐ Yes, full duty

Previous injuries to this area? Yes No

If yes, please explain: _____

**Patient Signature:** _____

**Provider Signature:** _____ Date: _____