Foot/Ankle Symptom Questionnaire

This information will help your doctor to understand your problem. Please complete the form as completely as possible. If you have any questions, do not hesitate to ask your doctor.

Name:____ Social Security #:____

Today's Date:_______________________________________ Date of Birth:____

Please Check One: ☐ Right Foot/Ankle ☐ Left Foot/Ankle ☐ Both Feet/Ankles (If both, is one more painful than the other? ☐ Yes ☐ No Which one?________________________________)

Please describe your problem:____.

When did your symptoms begin?____.

How did they begin?____.

Are they: ☐ Improving? ☐ Worsening? ☐ Staying the same?

Please describe your symptoms:

Level of discomfort (Circle one): Minimal 1 2 3 4 5 6 7 8 9 10 Severe

Where does it hurt? (Check all that apply):

☐ Top of foot ☐ Bottom of foot
☐ Inside of foot ☐ Outside of foot
☐ Inside of ankle ☐ Outside of ankle
☐ Other:____

How would you describe the pain? (Check all that apply):

☐ Sharp ☐ Dull ☐ Grinding
☐ Throbbing ☐ Tingling ☐ Intermittent
☐ Constant ☐ Burning ☐ Electric Shocks
☐ Other:____

Do you have any other associated symptoms? (Check all that apply):

☐ Stiffness Where?________________________________
☐ Numbness Where?________________________________
☐ Swelling Where?________________________________
☐ Locking/Catching Where?________________________________
☐ Weakness Where?________________________________
☐ Instability When?_________________________________

What makes your symptoms worse? (Check all that apply):

☐ Running ☐ Sports ☐ After activity
☐ Night ☐ Daytime ☐ During activity
☐ Stairs ☐ Other:_______________________________________

What makes your symptoms better? (Check all that apply):

☐ Rest ☐ Therapy ☐ Brace/Splint
☐ Heat ☐ Cold ☐ Walking Aid
☐ Exercise ☐ Other:_______________________________________

Do you have pain in other joints? ☐ No ☐ Yes Which ones?____

Have you had other tests? ☐ No ☐ Yes Describe:____

Have you had prior treatment? ☐ No ☐ Yes Describe:____