Family Foot and Ankle Care Inc. P.S.

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Physician and Surgeon of the Foot and Ankle
1100 SW Bowmer Drive
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Office: 360.679.3117 Fax: 360.679.3118

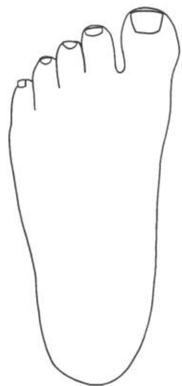
PATIENT NAME:____**DATE:**____________________________
DATE OF BIRTH: ____/_____/_______

CURRENT PROBLEM

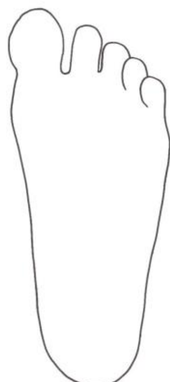
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

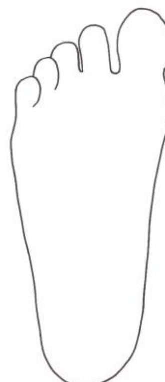


BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER ____

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WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ____________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ____________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ____________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

WHAT IS YOUR SHOE SIZE? ____________ NARROW MEDIUM WIDE (CIRCLE ONE)

DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES: LATEX ADHESIVE TAPE (PLEASE CIRCLE ALL THAT APPLY)

HOW DID YOU FIND OUT ABOUT OUR PRACTICE? ☐ PHYSICIAN ☐ INTERNET ☐ TELEPHONE BOOK ☐ FAMILY MEMBER ☐ FRIEND ☐ OTHER____________________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____
SIGNATURE OF DOCTOR

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
DATE

____
SIGNATURE

____
DATE