

Foot Pain Questionnaire



Πύργος Αθηνών, Κτίριο Γ', 2^{ος} όροφος, Λεωφ. Μεσογείων 2-4, Αθήνα 115 27

Τηλ.: 210 7712792 | Κινητό: 697 20 999 11 | E-mail: cky@orthosurgery.gr

Patient Name: _____

Date of Birth: _____

Date: _____

1. What is the main issue that brought you in today (circle all that are appropriate)?

- Pain
- Uncomfortable shoe wear
- Instability
- Deformity
- Sprain
- Failed surgery
- Bunion
- Recent injury
- Second opinion
-

2. How long has the current problem been going on? _____

3. Which side is involved? RIGHT LEFT BOTH

- If pain is the concern, please use an arrow to indicate the area on the diagram that hurts the most

- If more than one area of pain exists, please rank the sites from most to least painful (ie #1, #2, etc)

- If both sides are involved label the areas L (left) and R (right)



4. On a scale of 0 to 10 what is the level of pain? _____

5. Does this affect you mainly while standing (), sitting (), or both ()?

6. Is the problem improving (), worsening (), or staying the same ()?

7. Does this problem occur with shoes (), without shoes (), or both ()?

8. What % of sitting ____ and standing ____ do you have at work?

9. What activity are you unable to enjoy as a result of this condition?

10. Circle the treatments that you have tried until this point?

- Brace
- Physical Therapy
- Change of job
- Rest
- Prolotherapy
- New shoes
- Ice Massage
- Elevation
- Injection
- Chiropractor Surgery
- Anti-inflammatory
- Orthotic

• Is your problem related to an injury?_____ If yes, what kind?_____

• Where is your pain? Great toe, lesser toe, midfoot, hindfoot, ankle?_____

• How long have you had your pain?_____

• Is your pain worse in the morning, evening, or all day?

• What improves your pain?_____

• What worsens your pain?_____

• Do you wear orthotics?_____

• Do you have a personal history or family history of Diabetes? _____ If so, do you take insulin or medication by mouth? _____

• Has your foot size or shape changed recently?_____ If so, please explain _____

Physical Examination

- Age ___ Ht ___ Wt ___ Pulse ___ R e g / Irreg
- **Upper Extremities:** Normal / (Hyperlaxity Y N)
- **Standing:** Arch (Flat / Normal / High) Hindfoot (Varus / Neutral / Valgus)
- **Gait:** Normal / Antalgic (L R) / Slow / Unable
- **Single Heel Raise:** Normal / Painful (L R) / Unable (L R)
- **ROM:** R (A / H / TT / MTP /)
- L (A / H / TT / MTP /)
- **Ankle Stability:** Drawer R ___ L ___ Passive Inv R ___ L ___
- **Skin:**
- Right Left
- **Palpation: Hindfoot -**
- **Midfoot -**
- **Forefoot -**
- **Sensory:** DPN/SPN/Sur/Saph/Tib **Motor:** TA/EDL/PTT/FDL/ FHL/PL/PB/GS
- **Pulse:** ___ + DP, ___ +PT
- **Xray: Ankle - PMHx:** DM/RA/PVD
- **PSHx:**
- **Foot -**
- **Meds:**
- **Dx: All:**
- **Plan: Soc:** Smoke / Alc / Drugs
- **DME:**