

Cumberland Foot & Ankle Center

Name: _____

Phone: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- | | |
|---|---|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain in feet getting out of bed |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> "Toe-in" or "Toe-out" gait (walking) |
| <input type="checkbox"/> Heel or Arch pain | <input type="checkbox"/> Pain or fatigue of feet or legs in activity |
| <input type="checkbox"/> Leg pain (shin splints) | <input type="checkbox"/> Ankle instability (easy twisting injuries) |
| <input type="checkbox"/> Achilles tendon pain | <input type="checkbox"/> Difficulty/Pain with brisk walking or running |
| <input type="checkbox"/> Discoloration of toes/foot | <input type="checkbox"/> Pain legs occurs at same distance every time |
| <input type="checkbox"/> Ankle swelling or stiffness | <input type="checkbox"/> Coldness in the legs or feet that is uncomfortable |
| <input type="checkbox"/> Pain in feet or legs with exercise | <input type="checkbox"/> Non/Poor healing sore on the leg or foot |
| <input type="checkbox"/> Foot/Toes/Legs Burn | <input type="checkbox"/> Feet/Toes feel numb |

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

- | Tingling/Numbness in: | Pain radiating into: | Weakness of the: | Difficulty with: |
|--------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Toes R / L | <input type="checkbox"/> Foot R / L | <input type="checkbox"/> Sitting |
| | | | <input type="checkbox"/> Bending |
| | | | <input type="checkbox"/> Lifting |
| | | | <input type="checkbox"/> Kneeling |

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? Yes / No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

- I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.
- If it were available, I would be interested in receiving treatment for this condition in this office.
- If available, I would be open to have a medical test to further evaluate my problem.

Patient Signature