# Family Footcare, PC

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## Chief Complaint

Date: ____________________

### Reason for Todays Visit

**Patient Name:** ________________________________ Age: ______ Wgt: ______ Hgt: ______

Problem: ______________________________________________

Location: ______________________________________________

When did it start? ________ (How many?) Days Weeks Months Years Mode of onset? ☐ Acute ☐ Chronic

Timing of pain: ☐ Constant ☐ Morning ☐ Night ☐ As day goes on ☐ Activity related ☐ With walking

☐ With running/excercise ☐ Gets better with activity ☐ Start up pain Other: ____________________

Is the problem: ☐ Getting better ☐ Worse ☐ Staying the same Scale: 1 2 3 4 5 6 7 8 9 10

Is there swelling? ☐ Yes ☐ No Keeps you up at night? ☐ Yes ☐ No

Is there stiffness? ☐ Yes ☐ No Any clicking, laxity, giving out ☐ Yes ☐ No

Pain quality: ☐ Sharp ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Tingling ____________

What makes the pain better? ______________________________

What makes the pain worse? ______________________________

### Previoius Treatment

Have you had a similar condition in the past? ☐ Yes ☐ No ____________________

Have you seen another physician for this? ☐ Yes ☐ No Who?: ____________________

Did you go to the ER or an urgent care for this? ☐ Yes ☐ No ____________________

Have you had any testing for this? ☐ Yes ☐ No

☐ X-ray ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Conduction Other: ____________________

Have you had an injection for this? ☐ Yes ☐ No How many?: ____________

Have you gone to physical therapy? ☐ Yes ☐ No Did it help? ☐ Yes ☐ No

Have you had to use a mobility aid for this? ☐ Yes ☐ No

Which ones? ☐ Wheel chair ☐ Cane ☐ Walker ☐ Crutches ☐ Scooter Other: ____________

Have you been immobilized? ☐ Yes ☐ No

Cast / # weeks ______ Cam Boot/ #weeks ______ Brace/ # weeks ______ Night Splint/ # weeks ______ ☐ Orthotics

Have you had surgery for this? ☐ Yes ☐ No Who, what and when? ____________________

Anything else we need to know? ______________________________

If you have more that 1 complaint ask for additional sheet.

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