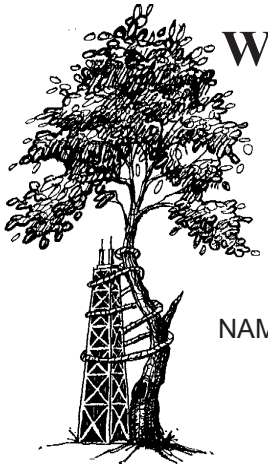


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue Chicago, Illinois 60659
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

TODAY'S DATE _____/_____/_____

PATIENT INFORMATION QUESTIONNAIRE: ANKLE/FOOT/TOES

NAME _____
FIRST MIDDLE LAST

HEIGHT _____ WEIGHT _____ AGE _____

I AM RIGHT HANDED **I AM LEFT HANDED** (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction Desk Job Driving Teacher

Executive/Professional Factory Homemaker Retired Sales Student

Other (Please List) _____

IF YOU ARE <u>NOT</u> WORKING NOW, WHEN DID YOU LAST WORK? _____/_____/_____

DOES IT REQUIRE LIFTING? **HOW OFTEN DO YOU LIFT THESE WEIGHTS?** (Please Circle)

None 10 lbs. or less 10-50 lbs. 50-100 lbs More than 100 lbs.
Rarely Frequently Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)

Squat Kneel Push Pull Climb Ladders/Stairs Stand Bend Stoop

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle) Yes No

Company Name _____ Company Phone (_____)_____

Company Address _____
STREET CITY STATE ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle) Yes No

Lawyer's Name _____ Lawyer's Phone (_____)_____

Lawyer's Address _____
STREET CITY STATE ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)

Right: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes

Left: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes

Back Neck Other (Please List) _____

_____

PLEASE <u>CIRCLE</u> YOUR <u>ONE MAJOR</u> COMPLAINT ! PLEASE <u>CHECK</u> (✔) ANY OTHER COMPLAINTS

Ankle/Heel Pain	Arch Pain	Ist Toe Pain
Lack of Sensation	Instability/Popping Out	Recurrent Sprains
Grinding/Popping/Noises	Something Moving Inside	Driving/Sitting
Locking/Catching	Loss of Activities/Work	Loss of Ankle/Toe Motion
Aching/Soreness	Deformity	Cutting/Thick Toenails
Running/Jumping	Stiffness	Swelling
Weakness/Drop Foot	Cold or Blue Feet/Toes	Ulcers/Calluses

Difficulty With: Standing Shoes Walking Walking on Uneven Ground Limping Climbing Stairs/Ladders

Any Other Complaints_____

_____

HAVE YOU EVER HAD AN ANKLE/FOOT/TOE INJURY OR PAIN? YES NO (See Last Page for Surgery)

WHEN? _____

_____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

An Injury : On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

I Don't Know When _____ Gradually Since _____

Other_____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR ANKLE/FOOT/TOES? Yes No

How long have you been off work? ____ days ____weeks ____ months _____ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR ANKLE/FOOT/TOES? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling	Hit By Object	Running/Jumping
Hit By Another Player	Slipped on Ice/Water	Tripping
Noncontact	Pulling/Pushing	Reaching
Twisting	Vehicle Accident	Ankle/Foot was run Over

Other_____

_____

INJURED DURING:(Please Circle)

Aerobics	Basketball	Baseball
Bicycling	Football	Handball
Racquetball	Running	Soccer
Skiing	Tennis	Volleyball

Other _____

AT THE TIME OF INJURY, DID YOU FEEL A RIP, POP OR TEARING? YES NO

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On _____ Time of Day _____ AM PM

Was any equipment, machinery and/or object involved in the accident? Yes No

If yes,please explain _____

_____

Was the accident reported to your supervisor and/ or employer at the time of the injury? Yes No

IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION

Vehicle Accident On _____/_____/_____ Time of Day _____ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? Yes No

Did you strike your head or lose consciousness? Yes No

If you were passenger,what was your position in the vehicle? _____

_

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other _____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other _____

_____

Was your vehicle moving when it was struck? Yes No How fast was it going? _____

Was the accident reported to the police? Yes No

What was the weather? _____

Did your vehicle strike another vehicle or object? Yes No Please Describe: _____

_____

Other _____

_____

_____

IF YOU ARE EXPERIENCING **PAIN**: PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have _____% Good Days _____ % Bad Days _____ % Average Days

LOCATION OF THE PAIN (Please Circle The Major Pain and Check (✔) Any OthersThat Apply)

Inside of Ankle/Foot	Outside of the Ankle/Foot	Top of the Foot
Heel	Achille's Tendon	Arch of foot
Ball of the foot	All Over	Deep Inside the Ankle/Foot

Top of the Bottom of the !st 2nd 3rd 4th 5th Toe All Toes

THE PAIN GOES TO: (Please Circle All Those That Apply)

Back of the Calf	Back of the Ankle	Front of the shin
Front of the Ankle	Top of the Foot	Bottom of the Foot
Top of the 1st Toe	Bottom of the 1st Toe	2n-5th Toes

Other _____

WHERE DID YOUR PAIN START? _____

WHERE DID YOUR PAIN SPREAD?(If Anywhere) _____

FREQUENCY OF PAIN: (Please Circle All Those That Apply)

Recent Onset	Occassionally	Irregularly
Unpredictable	Some Days	Most/ Every Day
Constantly	At Work	Most/Every Night
Even When Resting	With or After Activity/Sports	Initially But Not Now
Getting More Frequent	Getting Less Frequent	Frequency is Unchanged

Other _____

TIME OF DAY WHEN THE PAIN OCCURS: (Please Circle The MajorTime of Day and Check (✔) Any OthersThat Apply)

Morning	Late in the Day	Evening
Unpredictable	Irregular	Good & Bad Days
At Work	All Day/Constant	No Apparent Pattern to the Pains
Interrupts My Sleep	Other _____	

HOW OFTEN DO YOU WAKE UP AT NIGHT OR HAVE DIFFICULTY GOING TO SLEEP?

Never	Rarely/Sometimes	Most Nights
Every Night	I Can Sleep But Only When I Take Medicine	I Can't Sleep Even When I Take Medicine

THE PAIN IS:

Sharp/Knifelike	Dull	Aching
Electric Shock	Burning	Continuous
Worse in the Morning	Worse in the Evening	Soreness but not pain

Other _____

PAIN MADE WORSE WHEN:(Please Circle All Those That Apply)

Nothing Specific	Walking	Standing
Running	Sports	Jumping
Stairs/Ladders	Driving or Sitting	Housework/Yardwork
Squatting/Kneeling	Carrying Objects	Hills/inclines/uneven ground
Weather Changes	Pulling/Pushing	Coughing/Sneezing

Other _____

PAIN RELIEVED BY: (Please Circle All Those That Apply)

Nothing	Rest	Using a Walker/crutches/a cane
Activity	Heat	Cold/Ice
Medicine	Cortisone Injection	Moving the Ankle/foot/toes
Orthotics/Arch Supports	Wide Shoes	Prescription Shoes
Physical Therapy	Avoiding High heels	Wearing sandals/house slippers

Other _____

ANKLE/TOE RANGE OF MOTION: (Please Circle All those That Apply)

Normal	Can't Lift Ankle Up	Can't Point Ankle Down
Can't Lift Big Toe Up	Can't Point Big Toe Down	Can't Lift Other Toes Up

DO YOU HAVE ANKLE/FOOT/TOE PAIN WITH LIFTING:

Telephone Book or 1 Pint of Milk (1-2 lbs.)	Yes	No
Sack of Flour or 1 Gallon of Milk (5-10 lbs.)	Yes	No
A Small Child (25-50 lbs.)	Yes	No
50-100 lbs.	Yes	No
More Than 100 lbs	Yes	No

ACTIVITIES YOU CAN <u>NOT</u> DO BECAUSE OF THE ANKLE/FOOT/TOE PAIN : (Please Circle All those That Apply)

None	Running	Jumping	Sports
Put on Clothes/Shoes	Climb Stairs/Ladders	Walking	Standing
Wear High heels	Wear Tight Shoes	Walk on Uneven Ground	

Recreational activities I enjoy (Please List)_____

BECAUSE OF MY ANKLE/FOOT/TOE PAIN I HAVE TO SLEEP : (Please Circle)

I Have No Difficulty Sleeping	On My Back	On My Stomach
On the Affected Side	Sitting Up	Without Sheets Touching My Feet

NONPAIN SYMPTOMS/COMPLAINTS

MAXIMUM WEIGHT YOU CAN PUSH/PULL: None 25-50 lbs. 100 lbs. More than 100 lbs.

MAXIMUM WEIGHT YOU CAN CARRY: (Please Circle) Weight of the Arm Only

Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

MOBILITY OF THE ANKLE/FOOT: (Please Circle All those That Apply)

Able to Walk Normally	Able to Walk With a Limp	Able to Run Normally
Unable to Run	Unable to Walk Without a Cane, Crutches,Brace or Walker	

How Often Do You Limp or Need an Aid to Walk? Daily Once a Week Once a Month

Other _____

MAXIMUM TIME YOU COULD STAND IN ONE PLACE IF I PUT A GUN TO YOUR HEAD! (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

<u>MAXIMUM</u> DISTANCE YOU COULD WALK IF I PUT A GUN TO YOUR HEAD! (Please Circle)

From Bed to Wheelchair	Across the Room	Less Than 1 Block
1 to 4 Blocks	4 Blocks to 1 Mile	_____ Miles/Unlimited

Could you walk as far if you could not use an aid such as a cane or crutches? YES NO

DO YOU HAVE NUMBNESS,TINGLING, OR "PINS AND NEEDLES"? (Please Circle All those That Apply)

NONE	At First But Not Now	Constantly
At Night	Numbness/Tingling	Pins & Needles
Funny Feelings	Burning	

Where?_____

DO YOU FEEL CRUNCHING, GRINDING, SNAPPING, POPPING, GRATING OR "FUNNY NOISES"? (Please Circle)

Never Noticeable When Walking I Can Feel Them I Can Hear Them

Where?_____

ARE THE "NOISES" PAINFUL? YES NO

DO THE ANKLE/FOOT/TOES SWELL? (Please Circle All Those That Apply)

Never	Originally, But Not Since	Frequently/Daily
Daily	Doesn't Ever Go Away - Constant	When the Weather is Bad
Worst in the AM PM	After Popping Out or Dislocating	Only After Exercise or Use of the Joint

Other_____

DO THE ANKLE/FOOT/TOES GET "STUCK" OR "LOCK UP"? (Please Circle All Those That Apply)

Never	At First But Not Now	Just Started
Frequently	At Night	Catches But Does Not Truly Lock

Daily ____ Weekly ____ Monthly ____ How Many Total Times? _____

DO YOU HAVE WEAKNESS IN THE ANKLE/FOOT/TOES? Yes No

Where?_____

DO YOU FEEL THAT THE ANKLE/FOOT/TOE MUSCLES HAVE "SHRUNKEN" OR ATROPHIED? YES NO

DO YOU HAVE STIFFNESS IN THE ANKLE/FOOT/TOES? (Please Circle All those That Apply)

None	Always	After Activity or Sports
When Sitting/Driving	In the Morning	End of the Day

Other _____

HAVE YOU EVER HAD AN ARCH SUPPORT OR ORTHOTIC PRESCRIBED FOR YOU? YES NO

Did They Help? YES NO

HAVE YOU EVER HAD TO USED AN ANKLE BRACE? YES NO

WERE YOU EVER TOLD YOUR LEG LENGTHS WERE UNEQUAL AND YOU NEEDED A HEEL LIFT? YES NO

SHOES (Please Circle Any Shoes that CAUSE Pain and Check (✔) Any That Are COMFORTABLE)

Cetain Shoes Wide Shoes House Slippers Boots

High Heels Low Heels Sandals Athletic Shoes "High Top" Shoes

DO YOU WEAR OUT YOUR SHOES? Outer Heel Inner Heel Heel Counter Outer Toe Inner Toe

DO YOU HAVE? A Normal Arch A High Arch A Low Arch (Flatfoot)

HAVE YOU EVER HAD? (Please Circle All That Apply) Corns/Calluses/Blisters Varicose Veins

Ruptured Achilles Tendon Hammertoes Bunions Ulcers Plantar Fasciitis

If so, when? _____

IF YOU ARE A RUNNER,HOW MANY TIMES A WEEK DO YOU RUN? _____ Times per Week

HOW MANY MILES DO YOU RUN AT A TIME? _____ Miles at a Time

WHICH SPORTS MAKE THE PAIN WORSE? (Please List) _____

_____

WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN?ARE LIMITED IN THEM?(Please List)

_____

HAVE YOU OR DO YOU PARTICIPATE IN COMPETITIVE SPORTS AND AT WHAT LEVEL? (Please List)

_____

HAVE YOU EVER BROKEN A BONE, DISLOCATED A JOINT OR HAD ANY OTHER SERIOUS ORTHOPEDIC INJURY THAT DID NOT REQUIRE SURGERY? (Please List and Date Each) _____

_____

HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN? NO

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Darvocet-N-100(propoxyphene)	Motrin/Ibuprofen/Advil	Daypro(oxaprozin)	Dantrium(dantrolene)
Tylenol #3 (codeine)	Aspirin	Clinoril (sulindac)	Flexeril (cyclobenzaprene)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Skelaxin(metaxalone)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Robaxin(methocabamol)
Tylenol (acetaminophen)	Voltaren(diclofenac)	Relafin(nabumetone)	Neurontin (gabapentin)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Lyrica(pregabalin)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other _____

Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? _____

DOES THE MEDICATION HELP? Yes No Only A Little Bit

PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED

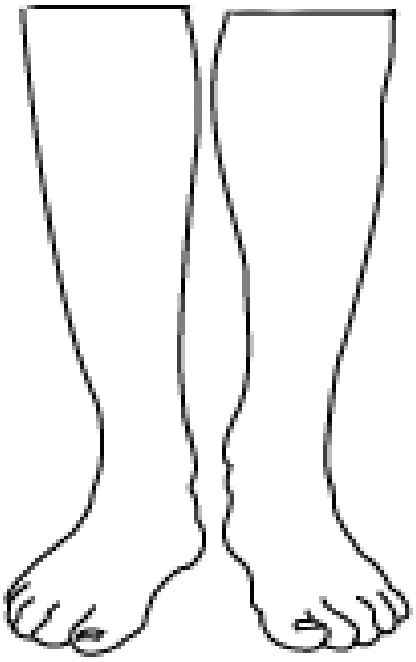
0 1-2 3-4 5-6 7-8 9-10

0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

How bad is your pain today?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the worst its ever been?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the best its ever been?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your lifestyle?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your work?	0	1	2	3	4	5	6	7	8	9	10
Do you have pain lying in bed or at rest?	0	1	2	3	4	5	6	7	8	9	10

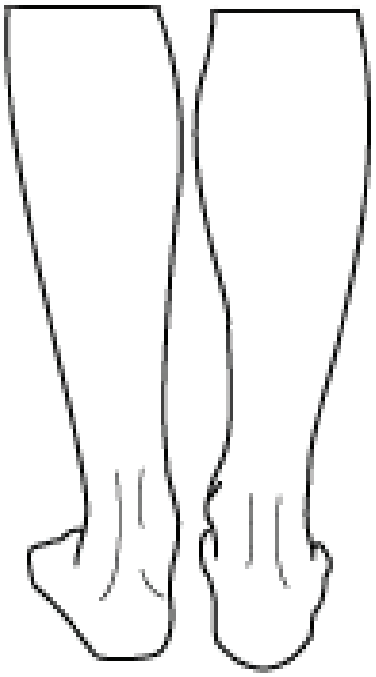
PLEASE DIAGRAM THE AREAS OF YOUR PAIN:

Burning [XXXX] Throbbing [✔✔✔✔] Sharp [////////] Aching [•••••] Numbness [✳✳✳✳]



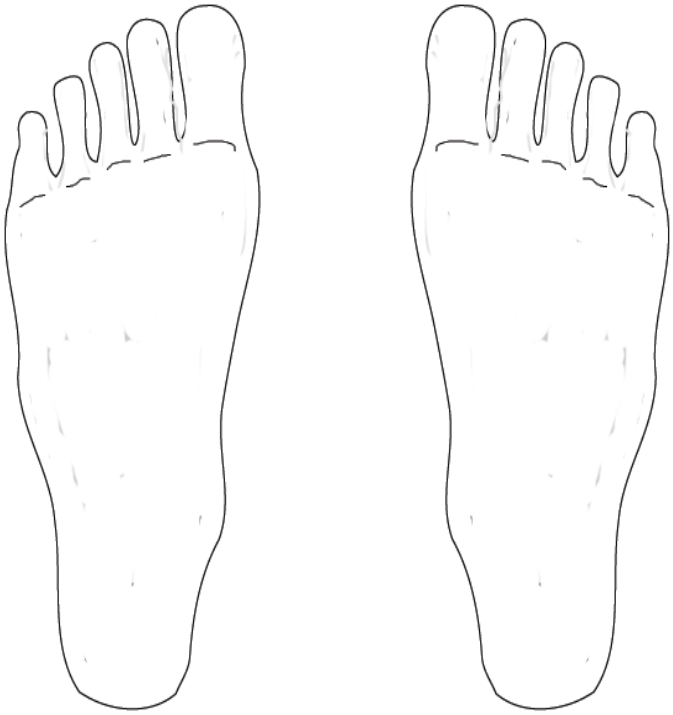
RIGHT LEFT

ANTERIOR



LEFT RIGHT

POSTERIOR



RIGHT LEFT

WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON? YES NO

Name _____ When _____

Diagnosis_____ Surgery (See Below)

WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU EVER HAVE X-RAYS TAKEN OF YOUR ANKLE/FOOT/TOES? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE AN ARTHROGRAM (dye test) DONE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

DID YOU HAVE A CAT SCAN OR MRI DONE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD PHYSICAL THERAPY (PT) OR A BRACE? YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

HAVE YOU EVER HAD SURGERY FOR YOUR ANKLE/FOOT/TOES? YES NO

#1 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#2 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#3 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#4 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

THANK YOU FOR PATIENCE IN FILLING OUT THIS FORM!