

Initial Evaluation

Patient History Form

Today's Date:

First Name: Last Name:

Age: Gender : Male/Female

Reason for visit (describe in own words)

Main symptom: Pain Swelling Deformity Instability Other
If other, please list:

Which body part: Left Right Both

Shoulder Calf Knee Elbow Ankle Foot Toe Heel Other

What aspect of body part:

Front (anterior) Back (posterior) Top (dorsal) Bottom (plantar)
Inner aspect (medial) Outer aspect (lateral)

Pain Description: Dull/aching Sharp Burning Other

Pain level of intensity: No Pain Mild Moderate Severe

Frequency: Occasional Daily Comes&Goes (intermittent) Constant

Rate your level of pain on the below scale by circling number:



How long have you had these symptoms? [] days/weeks/months/years []

Did they follow a fall/injury/accident/sports/surgery? Yes No

If yes, please describe []
If sports injury, which sport []

What types of activities make the symptoms worse? (circle or describe other) []
(for example: walking/standing/uneven ground/stairs/certain shoes/certain sports)
[]

What things make the symptoms better?
(for example: rest/ice/heat/medication/certain shoes/therapy/nothing)
[]

Have you seen anyone regarding this problem? Yes No
If yes, who have you seen? []

What treatments have you tried for the above condition?
[]

If referred to the office, by whom? []

Your Assessment of conditions affect on Your Function:

Check what best describes your present functional limitations:

- Activity Limitations
 - No limitations
 - No limitations of daily activities yet
Limited recreational activities
 - Limited daily and recreational activities
 - Severe limitation of daily and recreational activities
or use of cane, walker, crutches, wheelchair
- Footwear requirements
 - Fashionable, conventional shoes, no insert required
 - Comfort footwear and/or shoe insert or orthotic
 - Modified shoes or brace
 - N/A
- Maximum walking distances, blocks
 - Greater than 6 blocks
 - 4-6
 - 1-3
 - Less than 1
 - N/A
- Walking surfaces
 - No difficulty on any surface
 - Some difficulty on uneven ground, stairs, inclines, ladders
 - Severe difficulty on uneven ground, stairs, inclines, ladders
 - N/A

Medical History: (check box if you have/had any of the conditions below)

No medical illnesses

<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal Disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Back Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No Lupus
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Clot (Lower leg or Lungs)	<input type="checkbox"/> Yes <input type="checkbox"/> No Paralysis
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis
What Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Gout	<input type="checkbox"/> TB
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Coronary Artery	
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve	
<input type="checkbox"/> Yes <input type="checkbox"/> No Arrhythmia/Irregular Rhythm/Rate	

Past Medical History:

Surgical History: No previous surgery

<input type="checkbox"/> Yes <input type="checkbox"/> No Appendix	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney
<input type="checkbox"/> Yes <input type="checkbox"/> No Back/Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No Prostate
<input type="checkbox"/> Yes <input type="checkbox"/> No C-section	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid
<input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder	<input type="checkbox"/> Yes <input type="checkbox"/> No Tonsils
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer (Type _____)
<input type="checkbox"/> Yes <input type="checkbox"/> No Hysterectomy/Ovaries	<input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____

Medications: (please list meds and doses if known) None

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Allergies to Medications: None Known

Penicillin Sulfa drugs Iodine Other (list below)

1. _____ 2. _____ 3. _____

Social History:

Do you smoke? No Yes If Yes, packs per day? _____ Drug Overuse? Never
Alcohol Use? No Occasional Moderate to Heavy Present
Present Occupation: _____ Past Problem

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Patient Name:
DOB:

Family History:

<input type="checkbox"/> Health Status or cause of Death of parents, siblings, and children ██████
<input type="checkbox"/> Hereditary or high risk diseases. ██████
<input type="checkbox"/> Diseases related to your chief complaint, History Of Present Illness and/or Review Of Systems ██████

Review of Systems:

<input type="checkbox"/> Yes <input type="checkbox"/> No Prior problem with Anesthesia What Problem: ██████	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Urination
<input type="checkbox"/> Yes <input type="checkbox"/> No Disease of the Eye, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath
<input type="checkbox"/> Yes <input type="checkbox"/> No Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Heart Beat
<input type="checkbox"/> Yes <input type="checkbox"/> No Hiatal Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No Fever or Chills
<input type="checkbox"/> Yes <input type="checkbox"/> No Peptic Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No Muscle Pain
<input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Other Joint Pain/Stiffness
<input type="checkbox"/> Yes <input type="checkbox"/> No Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Leg/Skin Ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Leg Cramps while walking
	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness/Addiction

Patient Signature: ██████ Date: ██████

Physician Signature: ██████ Date: ██████