Foot and Ankle Questionnaire

ALTA ORTHOPAEDICS

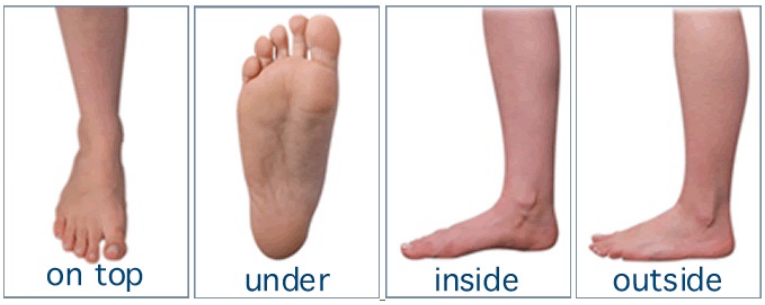
Name: _____ **Date:** _____

Area of problem: ◯ Right ◯ Left ◯ Both

◯ Ankle ◯ Foot ◯ Toe ◯ Arch ◯ Heel ◯ Achilles
◯ Bunion ◯ Hammer toe ◯ Other _____

Type of problem: ◯ Pain ◯ Swelling ◯ Instability ◯ Stiffness
◯ Deformity ◯ Numbness ◯ Other _____

Please mark the area:



If pain, how would you describe it? ◯ sharp ◯ dull ◯ aching
(check all that apply) ◯ burning ◯ cramping ◯ other _____

When did the problem start? _____

Timing: ◯ constant ◯ intermittent ◯ daily ◯ wakes me up at night

How severe is the problem? ◯ Mild ◯ Moderate ◯ Severe

Please indicate severity: Minimal pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Overall, this is getting: ◯ better ◯ worse ◯ staying the same

How did the problem start? _____

What makes it worse? _____

What makes it better? _____

Have you been seen for this problem before? ◯ Yes ◯ No If Yes, by who?_____

What treatments have you tried?

◯ none ◯ rest ◯ ice ◯ heat ◯ physical therapy
◯ brace ◯ orthotics ◯ cast ◯ injections ◯ acupuncture
◯ medication (list)_____ ◯ other: _____

Please list all surgeries you have had on your foot or ankle including dates:

_____