

	PENINSULA ORTHOPAEDIC ASSOCIATES		Name:	
	New Problem Foot and Ankle		POA ID#:	
			Date:	
			Birth Date:	Age:
			Primary Care Physician:	

What is the name of the medical provider who sent you here today? _____

	RIGHT	LEFT
Does your ankle hurt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your foot hurt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When did the problem start?		
Did you have an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what injury did you have?		
Where is the pain?	<input type="checkbox"/> Outer side <input type="checkbox"/> Inner side <input type="checkbox"/> Top <input type="checkbox"/> Bottom	<input type="checkbox"/> Outer side <input type="checkbox"/> Inner side <input type="checkbox"/> Top <input type="checkbox"/> Bottom
What does the pain feel like?	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning
Is the pain?	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still
How bad is the Pain	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible
Did you hurt yourself at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you involved in litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<i>For workers' compensation and litigation patients only</i>		
	RIGHT	LEFT
Did you have pain before the injury at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when did it start?		
How bad was the pain prior to the work /litigation injury?	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible
How long after the work /litigation injury did the pain start?		