Foot and Ankle Questionnaire

ALTA ORTHOPAEDICS

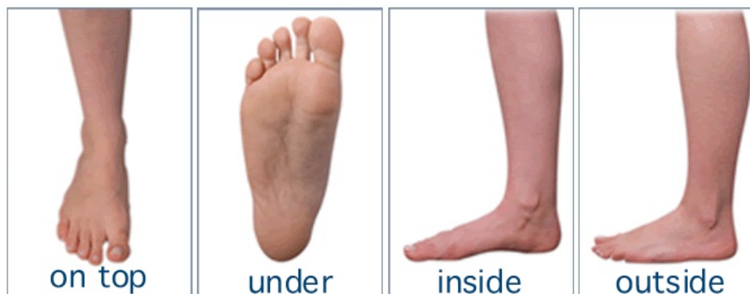
Name: ____ **Date:** ________________

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:

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