Instructions

1. Please read over the choices carefully
2. For each positive response the box must be completely darkened in
3. For each negative response leave the box blank
4. If you have any questions or need assistance please contact our office at 630.778.7670

-Reason for your visit (please check all that apply):

- ☐ Corns/Callous
- ☐ Pain
- ☐ Heel pain Left ___ Right ___ Both ___
- ☐ Arch pain Left ___ Right ___ Both ___
- ☐ Ball of foot Left ___ Right ___ Both ___
- ☐ Foot Left ___ Right ___ Both ___
- ☐ Top ______ Left ___ Right ___ Both ___
- ☐ Ulcer treatment
- ☐ Ingrown treatment(s)
- ☐ Bunions(s)
- ☐ Hammertoes(s)
- ☐ Tingling in feet
- ☐ Fungus
- ☐ Injury
- ☐ Other: ________________________

-Location of pain: ____

-Intensity on a scale from 1-10 1 being low, 10 being high): ________________

-Duration (how long have you had it): ____________________________________

-Relieving factors (rest, ice, heat, stretching, other): _______________________

-Medication or other remedies tried: _____________________________________

-Have you had any previous treatment for this problem? Yes or No

If yes please explain ______________________________________

-Have you had any X-Rays, MRI's, or Ultrasounds for this problem? Yes or No

If yes when: _____________________ where: ___________________

-Is this an injury? Yes or No

If yes when did it occur? ____________________________________

Where did it occur? ____

How did it occur? ____

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