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? _____