Patient Questionnaire - Knee, Ankle, Foot and Leg

Date: ______________

(Please be thorough and fill out all that is applicable)

Patient (print): ________________________________ **Date of Birth:** ____________ **Age:** ________

Date of Injury or Onset of Symptoms: ____________ **Return to Doctor Appointment:** ___________

Date of Surgery: ______________ **Type of Surgery:** ____________________________________

Please provide a brief history of your present condition and how did this begin: ________________

____

Your primary concern/chief complaint about your *CURRENT* condition: ______________________

____

CURRENT **Limitations of Function — Check *ALL* areas you *ARE CURRENTLY LIMITED*:**

- ❑ Self Care: Cooking, Shopping, Cleaning
- ❑ Mobility: Walking & Moving Around
- ❑ Changing & Maintaining Body Position
- ❑ Carrying, Moving & Handling Objects

CURRENT **Level of Function —** (% of your ***normal*** ability): ❑ 0% (unable to care for self) ❑ 10% ❑ 25% ❑ 50% ❑ 75% ❑ 100% ❑ Other: ___%

Pain Location: (*be specific*): ❑ Left ❑ Right ❑ Both ❑ Toes, Which one(s): ______________________

____

What is the intensity of your *PRIMARY SOURCE OF PAIN* (i.e., why you are beginning Hand Therapy)? **0 = None** **5 = Moderate** **10 = Extreme**

	0	1	2	3	4	5	6	7	8	9	10
Circle your pain at its' ***LOWEST:***	0	1	2	3	4	5	6	7	8	9	10
Circle the pain you have ***RIGHT NOW:***	0	1	2	3	4	5	6	7	8	9	10
Circle your pain at its' ***HIGHEST:***	0	1	2	3	4	5	6	7	8	9	10

Describe your pain — Check *ALL* areas that apply:

- ❑ Burning ❑ Sharp ❑ Numbness/Tingling ❑ Throbbing ❑ Shooting
- ❑ Dull/Achy ❑ Other(s), Describe: ________________
- ❑ If numbness, tingling, and/or shooting ***where does the pain START and END***? ________________

____

What aggravates your pain — Check *ALL* areas that *INCREASE(S)* your pain:

- ❑ Sitting ❑ Standing ❑ Sit-to-Stand ❑ Bending ❑ Walking
- ❑ Going to the Restroom ❑ Coughing/Sneezing ❑ Lying Down ❑ Driving ❑ Lifting/Carrying
- ❑ Other(s), Describe: ____

What can you do to decrease your pain — Check *ALL* areas that *DECREASE(S)* your pain:

- ❑ Sitting ❑ Standing ❑ Walking ❑ When Still ❑ Mornings ❑ Evenings
- ❑ Lying Down ❑ Movement: Describe: ____
- ❑ Other(s), Describe: ____

Name of Occupation: ______________ **Out of Work Since:** ________ **Return to Work Date:** ________

Work Status — Check the *ONE* that best describes your status: ❑ Full Time ❑ Part Time
❑ Light Duty ❑ Transitional Duty ❑ Out of Work ❑ Retired ❑ Not Working ❑ Homemaker

Description of your Occupation: ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy ❑ Very Heavy

Is there an attorney involved? ❑ Yes ❑ No **— Who?** ______________ **Attorney's Office #:** _________

Medical History — Check *ALL* that apply *AND* provide descriptions:

❑ Osteoarthritis ______________________________

❑ Diabetes Mellitus: __________________________
If yes: ❑ Type 1 ❑ Type 2
Managed: ❑ Insulin ❑ Meds. ❑ Diet

❑ Currently Pregnant _________________________

❑ Cancer: ___________________________________

❑ Epilepsy/Seizures __________________________

❑ Migraines/Headaches _______________________
If yes, is the pain: ❑ Greater on one side
❑ Equal on both sides

❑ Prior Therapy: ❑ OT ❑ PT ❑ Chiropractic
For: ______________________________________

❑ Implantable medical device(s)________________
❑ Pacemaker
❑ Defibrillator
❑ Other: ________________________________

❑ Cardiovascular Disease _______________________

❑ Emotional/Psychological ______________________

❑ Allergies ____________________________________

❑ Asthma ______________________________________

❑ Smoking: _____________________________________
If yes: Packs per day: _______
Quit? __ year(s) __ month(s) __ week(s) __ day(s)

❑ Dizziness/Fainting: Describe: __________________
❑ Trigger(s):________________________________
❑ How Long Does the Dizziness Last:___________

❑ Surgical History__________________________

❑ Splint/Cast/Sling: If so, how long? _______________
Type: ____

❑ History of Falls: ❑ Yes ❑ No, If Yes, Explain:
____

Diagnostic Testing/Procedures — Check *ALL* that apply *WITH DATES & RESULTS:*

❑ CT - Date: ________________
Results: __________________

❑ MRI - Date: ________________
Results: ____________________

❑ EMG - Date: ____________________
Results: _____________________

❑ Myelogram - Date: _________
Results:___________________

❑ Bone Scan - Date: __________
Results: ____________________

❑ Other ___________ - Date: _______
Results: _______________________

❑ Steroid Injections in Muscles - Date: ______________
Results ____

❑ Epidural Steroid Injections - Date: __________
Results ___________________________________

Current Medications — Check *ALL* that apply *AND* provide dosages — Attach a list if necessary

❑ Not Currently Taking Any Medications ❑ Prescription_______________________________________

❑ Over The Counter________________ ❑ Herbals____

❑ Vitamins & Minerals______________ ❑ Dietary & Nutritional Supplements ______________________

What are your Hobbies? ____

What are your Physical Therapy Goals? ____

Current Weight: _________________ **Current Height**: __________________

Lower Extremity Functional Index

PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80