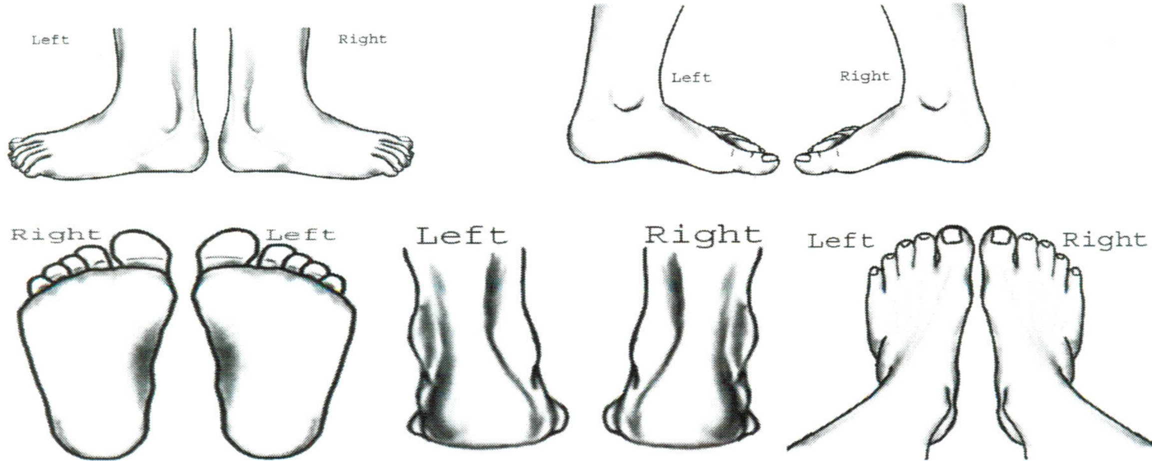
NORTH IDAHO
FOOT & ANKLE INSTITUTE

1. Please "X" the problem area in the pictures:



2. What does the pain feel like?

☐ Aching ☐ Deep ☐ Sharp ☐ Stabbing ☐ Burning ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Tingling ☐ Numb

3. What date did this problem start? ____________________

4. How did the symptoms start? ☐ Suddenly ☐ Gradually ☐ Slowly ☐ With an injury

5. Which best describes your pain? ☐ Getting worse ☐ Getting better ☐ Staying the same

6. Does it hurt more with: ☐ Activity ☐ Shoes ☐ Standing ☐ Resting

7. Have you tried conservative treatment? Yes or No

If yes, have you tried: ☐ Different Shoes ☐ Orthotics ☐ Ibuprofen ☐ Icing ☐ Therapy
☐ Stretching ☐ Other ______________________

8. Does this condition affect your normal daily activities or work? Yes or No

9. If this problem was caused by an injury, was it work related? Yes or No

10. Please circle the face below that best describes your typical daily pain:

0 1-2 3-4 5-6 7-8 9-10

Today's Date ____________________

Signature ________________________

Printed Name ______________________

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