Podiatric Pain Analysis Survey

Affiliated Foot & Ankle Center, LLP

PODIATRIC MEDICINE • FOOT & ANKLE SURGERY • SPORTS MEDICINE

Dr. Alison DeWaters • Dr. Varun (Ben) Gujral • Dr. Jasen Langley • Dr. Hal Ornstein

4645 Hwy 9 North, Howell NJ 07731 • 2163 Oak Tree Road, Suite 108, Edison NJ 08820

300 Overlook Road, Monroe NJ 08831• 32 Tennyson Street, Carteret, NJ 07008

Name: _____

Phone: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- ☐ Flat Feet
- ☐ Poor coordination
- ☐ Heel or Arch Pain
- ☐ Leg pain (shin splints)
- ☐ Achilles tendon pain
- ☐ "Toe-in" or "Toe-out" gait (walking)
- ☐ Ankle swelling or stiffness
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Ankle instability (easy twisting injuries)
- ☐ Have you had a Deep Vein Thrombosis (DVT) and are experiencing pain, swelling,
- ☐ Change in skin color, cellulites, or non-healing ulcers?
- ☐ Pain in feet or legs at rest
- ☐ Pain in feet or legs with exercise or activity
- ☐ Feet/Toes feel numb
- ☐ Foot/Toes/Legs burn
- ☐ Difficulty/Pain with brisk walking or running
- ☐ Discoloration of toes/foot
- ☐ Pain legs occurs at the same distance every time
- ☐ Coldness in the legs or feet that is uncomfortable
- ☐ Non / Poor healing sore on the leg or foot
- ☐ Do your legs feel heavy, tired, restless, or achy

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:	**Pain radiating into:**	**Weakness of the:**	**Difficulty with:**
☐ Legs R / L	☐ Ankle R / L	☐ Legs R / L	☐ Standing
☐ Ankle R / L	☐ Feet R / L	☐ Ankle R / L	☐ Walking
☐ Feet R / L	☐ Toes R / L	☐ Foot R / L	☐ Sitting
			☐ Bending
			☐ Lifting
			☐ Kneeling

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? ☐ Yes ☐ No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

☐ I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.

☐ If it were available, I would be interested in receiving treatment for this condition in this office.

☐ If available, I would be open to have a medical test to further evaluate my problem.

_____	_____
Patient Signature	Physician Signature