

# Pain Analysis Survey



Name: \_\_\_\_\_

DOB \_\_\_\_\_

Do any of the following apply to the patient:

\_\_\_\_ Flat Feet                      \_\_\_\_ Pain in the feet when getting out of bed

\_\_\_\_ Poor Coordination              \_\_\_\_ "Toe IN"/ "Toe Out" Gait

\_\_\_\_ Pain/Fatigue in legs/ Feet During Activity

\_\_\_\_ Heel/Arch Pain                      \_\_\_\_ Leg Pain (Shin Splints)

\_\_\_\_ Ankle Instability (easily twisting injuries)

\_\_\_\_ Ankle Swelling/ Stiffness      \_\_\_\_ Difficulty with brisk walking/running

\_\_\_\_ Achilles Tendon Pain              \_\_\_\_ Other

If you have any of the above conditions which are of most concern to you?

\_\_\_\_\_

Is the above name condition causing or are you suffering with any of the following?

Tingling IN:

Legs R/L      Ankle R/L      Feet R/L      Toes R/L    1 2 3 4 5

Pain Radiating Into:

Legs R/L      Ankle R/L      Feet R/L      Toes R/L    1 2 3 4 5

Difficulty Standing/ Walking/Sitting/Bending/Lifting/Kneeling:

Legs R/L      Ankle R/L      Feet R/L      Toes R/L    1 2 3 4 5

How long have you been suffering with this condition?\_\_\_\_\_

How is the condition affecting you daily?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Would you like to get rid of the problem?    Yes    No

Would you like to discuss the above condition with the Doctor?    Yes    No

Please choose one:

Would you like to be treated in this office?

Another Facility?

Not interested in treatment at this time

Patient Signature/Date:\_\_\_\_\_

Assistant Initials:\_\_\_\_\_