

FOOT QUESTIONNAIRE

NAME: _____ DATE: _____

HOW LONG HAS YOUR FOOT BEEN HURTING? _____

IS THE PAIN CONSTANT OR INTERMITTENT? (CIRCLE)

HOW DID YOUR CONDITION START? _____

IS IT WORSE RIGHT AFTER YOU GET OUT OF BED OR AFTER YOU HAVE BEEN ON IT?

DOES YOUR PAIN WAKE YOU UP AT NIGHT? Y N

DO YOU HAVE NUMBNESS IN YOUR FOOT OR TOES? Y N

ARE YOU DIABETIC? Y N

DO YOU WEAR HEEL CUPS, ORTHOTICS, INSERT PRODUCTS? Y N

IF SO DO THEY HELP? Y N

WHAT MAKES YOUR PROBLEM WORSE? _____

WHAT MAKES YOUR PROBLEM BETTER? _____

ARE YOU TAKING ANY MEDICATIONS FOR YOUR FOOT PAIN INCLUDING OVER THE COUNTER

DRUGS? Y N PLEASE LIST _____

HAVE YOU SEEN ANY OTHER DOCTORS OR HEALTH CARE PROVIDERS FOR THIS COND-

ITION? Y N PLEASE LIST NAMES AND TREATMENTS RENDERED _____

HOW MANY HOURS PER DAY ARE YOU STANDING OR WALKING? _____

IS YOUR WORK SURFACE CONCRETE? Y N

HAVE YOU BEEN OFF WORK DUE TO THIS CONDITION? Y N

IF SO HOW LONG? _____