Name:

Foot Pain Questionnaire

When did your pain start?----------

How did your pain start? Ie gradual, sudden, accident----------

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Can you describe your pain ie aching/burning ----------

Where is your pain? Does it radiate anywhere?----------

On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine,

How do you rate your pain on your best day---------- your worst day----------

Has your pain been getting better/worse/staying the same?----------

What makes your pain better resting stretching etc?----------

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What makes your pain worse?----------

Is your pain constant or does it come and go?----------

Do you have any new weakness? ----------

Do you have numbness or tingling in your feet?

Does your ankle swell?----------

Name:

Does your foot hurt first thing in the morning?----------

Do you have any other joints that have been red, hot or swollen?----------

Do you have any skin rashes ie psoriasis?----------

Have you ever had an allergic reaction/rash from the sun?----------

In terms of your function does your foot pain affect your

1. Ability to sit?_____
2. Ability to walk?_____
3. Ability to stand?_____
4. Ability to go up and down stairs?_____
5. Ability to sleep?_____
6. Ability to work?_____
7. Ability to participate in recreational activities?_____

Have you tried any of the following treatments? If so, were they successful?

Physiotherapy----------

Orthotics----------

Injections----------

Massage----------

Medications----------

Surgery----------

Name:

Acupuncture----------

Have you had any investigations for this problem? ie CT, x-ray, MRI. Where and when?----------

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Please tell me about any medical conditions you have----------

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Please list any surgeries you have had in the past----------

Please list your medications----------

Please list any drug allergies----------

Please tell me a bit about yourself...

What do you do/did you do for work?----------

Do you do a regular exercise program? If so, what type of exercise and how frequently?----------

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Are you a smoker Yes or No? Is there a past history of smoking?----------

How much alcohol would you drink in a week?----------

Caffeine:----------

What are your hopes for today's visit?----------

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

1. **General Activity:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

2. **Mood:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

3. **Walking Ability:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

4. **Normal Work (includes both work outside the home and housework)**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

5. **Relations with other people:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

6. **Sleep:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

7. **Enjoyment of Life:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes