DES MOINES UNIVERSITY FOOT AND ANKLE CLINIC
3200 Grand Avenue, Des Moines, IA 50312

Patient Name: _____ Date of Birth: _____ Age: _____ DATE: _____

What is bothering you today? _____
_____
_____

When did this happen? _____

How did this happen?_____

Mark the location of the problem(s) with an X

Select all that apply with an X that best describes your pain.

Burning_____ Gnawing____ Aching_____ Weakness___ Numbness___ Tingling_____ Stabbing_____ Shooting _____ Full_____ Other (Describe)_____

Is your pain constant? Yes___ No___

If "10" is the worst pain or discomfort you ever had and "0" is no pain or discomfort, how would you rate your pain or discomfort today? (Circle number)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Is there anything that makes the symptoms better or worse? Yes___ No___

What have you done to treat it? Orthotic_____Brace_____Anti-inflammatory_____

Lotion/Cream_____Antibiotic_____Changed shoe_____

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN AND DATE SIGNATURE OF DOCTOR AND DATE