Foot Questionnaire

Please Only Fill This Form Out If YOU Are Experiencing This Pain!

If You Do Not Have This Pain Then Skip This Form!

1. Which foot are you feeling pain? Left Right Both

   Where in your Feet are you feeling pain?

   Top Bottom Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10?
   One is no pain, ten is severe pain.

   1 2 3 4 5 6 7 8 9 10

3. When the pain is at its worst what number would you rate it?
   One is no pain, ten in severe pain.

   1 2 3 4 5 6 7 8 9 10

4. When the pain is at its best what number would you rate it?

   One is no pain, ten in severe pain.

   1 2 3 4 5 6 7 8 9

5. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

6. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: _____

7. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

Patient Name: _____

8. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

9. When is the pain at its worst?

Morning Afternoon Evening All Day

10. What caused this pain? What were you doing when you first felt the pain?

_____

_____

Patient Name: _____