Initial Visit Information

PATIENT NAME _____ DATE OF VISIT _____

WHO REFERRED YOU TO THIS OFFICE? _____

EXPLAIN YOUR REASON(S) FOR SEEING THE DOCTOR TODAY _____

IS THE PROBLEM THE RESULT OF AN ACCIDENT OR INJURY (no) (yes) If yes, explain _____
Have you seen another doctor for this condition? If so who? _____
What diagnosis and treatment were given? _____
IS THE PROBLEM PRESENT all of the time / part of the time / comes and goes
HOW LONG HAVE YOU HAD THE SYMPTOMS? _____
IS THE PAIN ASSOCIATED WITH A PARTICULAR SITUATION? _____
_____
(standing, walking, sports, getting up in morning, keeps awake at night, specific shoes, running, etc.)
IS THERE ANYTHING THAT MAKES THE SYMPTOMS BETTER? _____
WORSE? _____
Do you have a job that requires you to be on your feet? _____
What type of footwear do you wear for work/ school? _____
Do you participate in any of the following activities? Walking, Running, Baseball, Basketball, Soccer, Hockey, Football, Tennis, Gymnastics, Dance, Volleyball, Golf, Biking, Track, Cross Country, Marathons, Triathalons, Other _____
How long have you been participating? _____
Are you currently training for a special competition, meet, race, etc. What & when? _____
_____
Have you had prior sports injuries? Explain _____
Do you wear orthotics? _____ from where? _____
Circle the type(s) of pain you're having: burning / throbbing / aching / gnawing / stabbing / shooting / fullness / Numbness / hard to describe – just hurts / other _____
How severe is the pain? (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

Mark the location of your problems with an "X"
Indicate left or right or both.