# Right Step Foot Care

Name: _____

Phone: _____ Age: _____

**Please check any of the following conditions you are currently experiencing or suffering from:**

- ☐ Flat Feet
- ☐ Poor coordination
- ☐ Heel or Arch Pain
- ☐ Leg pain (shin splints)
- ☐ Achilles tendon pain
- ☐ Discoloration of toes/foot
- ☐ Ankle swelling or stiffness
- ☐ Pain in feet or legs with exercise
- ☐ Foot/Toes/Legs Burn
- ☐ Pain in feet getting out of bed
- ☐ "Toe-in" or "Toe-out" gait (walking)
- ☐ Pain or fatigue of feet or legs in activity
- ☐ Ankle instability (easy twisting injuries)
- ☐ Difficulty/Pain with brisk walking or running
- ☐ Pain legs occurs at the same distance every time
- ☐ Coldness in the legs or feet that is uncomfortable
- ☐ Non / Poor healing sore on the leg or foot
- ☐ Feet/Toes feel numb

**Please answer the following about the above conditions:**

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

| **Tingling/Numbness in:** | **Pain radiating into:** | **Weakness of the:** | **Difficulty with:** |
|---|---|---|---|
| ☐ Legs R / L | ☐ Ankle R / L | ☐ Legs R / L | ☐ Standing |
| ☐ Ankle R / L | ☐ Feet R / L | ☐ Ankle R / L | ☐ Walking |
| ☐ Feet R / L | ☐ Toes R / L | ☐ Foot R / L | ☐ Sitting |
| | | | ☐ Bending |
| | | | ☐ Lifting |
| | | | ☐ Kneeling |

How long have you been suffering with this condition? Days / Weeks / Months / Longer

How is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? ☐ Yes ☐ No

**There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.**

☐ I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.

☐ If it were available, I would be interested in receiving treatment for this condition in this office.

☐ If available, I would be open to have a medical test to further evaluate my problem.

_____

Patient Signature