

**MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA**  
 For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE **Physical Therapy Medical History Intake Form** Ankle Problem

OTSG APPROVED (Date)

MOS/Occupation: \_\_\_\_\_  
 Duty Station/Unit: \_\_\_\_\_  
 When did symptoms start (date): \_\_\_\_\_  
 Symptoms related to deployment? Yes-Combat Yes-NonCombat No  
 Have you had these symptoms before? Yes No  
 How did symptoms start? \_\_\_\_\_  
 Symptoms are? Constant Come/Go Only with Activity  
 Symptoms are? Getting worse Not Changing Getting Better  
 List any medications or dietary supplements your are taking:

\_\_\_\_\_ None  
 List any drug or latex allergies you are aware of: \_\_\_\_\_ None  
 List Assistive Devices you use (crutches, braces, shoe inserts): \_\_\_\_\_ None

Are you in the Personal Reliability Program (PRP)? Yes No  
 Have you completed advanced medical directives? Yes No  
 (aka: "living will") Information is available at front desk.  
 Do you have difficulties with? (check all that apply)  
Communication Vision None  
Speech Hearing Other: \_\_\_\_\_

Mark an "X" on the lines below that best describes your response.

**1. Which activity causes you the most pain / most trouble performing?**

**Function:** Rate your ability to perform the *above* activity.  
 0 1 2 3 4 5 6 7 8 9 10  
 Unable to Perform No restrictions

**2. Pain at WORST: Rate your highest pain level in past 72 hrs.**

0 1 2 3 4 5 6 7 8 9 10  
 No pain Worst pain Imaginable

**3. Pain at BEST: Rate you lowest pain level in past 72 hrs.**

0 1 2 3 4 5 6 7 8 9 10  
 No pain Worst pain Imaginable

**4. Impact: How distressing is this condition to you?**

0 1 2 3 4 5 6 7 8 9 10  
 No problem Devastating

**Medical History:**

|                                 | <u>Self</u> |    | <u>Family</u> |    |
|---------------------------------|-------------|----|---------------|----|
| Cancer?                         | Yes         | No | Yes           | No |
| Diabetes?                       | Yes         | No | Yes           | No |
| High Blood Pressure?            | Yes         | No | Yes           | No |
| Heart Disease?                  | Yes         | No | Yes           | No |
| Osteoporosis?                   | Yes         | No | Yes           | No |
| Osteoarthritis?                 | Yes         | No | Yes           | No |
| Rheumatoid arthritis?           | Yes         | No | Yes           | No |
| Neurologic dz (MS, Parkinsons)? | Yes         | No | Yes           | No |
| Ulcers / GERD / Acid Reflux?    | Yes         | No | Yes           | No |
| Kidney / Liver Disease?         | Yes         | No | Yes           | No |
| Prior Surgeries:                | Yes         | No |               |    |

**Other:** \_\_\_\_\_

**In the past 3 months have you had or do you experience:**

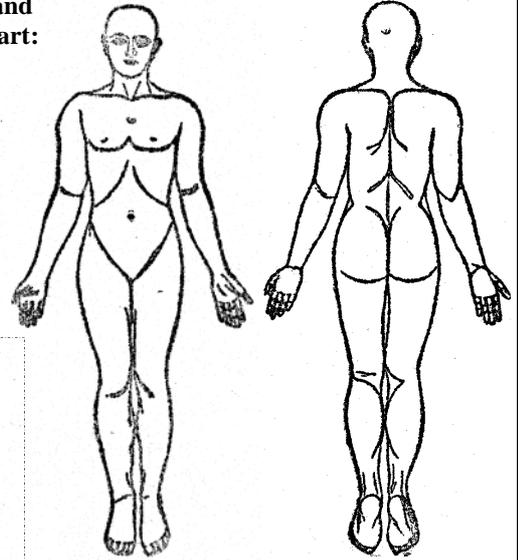
|                                      |     |    |
|--------------------------------------|-----|----|
| Change in your general health?       | Yes | No |
| Fever / chills / sweats?             | Yes | No |
| Unexplained weight change (>10lbs)?  | Yes | No |
| Numbness or tingling?                | Yes | No |
| Bowel / bladder incontinence?        | Yes | No |
| Difficulty sleeping due to pain?     | Yes | No |
| Unexplained Falls/Decreased balance? | Yes | No |

**Are you currently/Do you have:**

|  |    |     |    |
|--|----|-----|----|
| Pregnant / Potentially Pregnant / Nursing?                     | NA | Yes | No |
| Often bothered by feeling down, depressed, or hopeless?        |    | Yes | No |
| Often bothered by little interest or pleasure in doing things? |    | Yes | No |
| Under physical / emotional abuse?                              |    | Yes | No |
| Dietary or Nutritional Concerns?                               |    | Yes | No |
| Do you use tobacco products?                                   |    | Yes | No |

**Indicate the location and type of pain on the chart:**

**Key:**  
 Ache/Dull: ^ ^ ^ ^  
 Sharp/Stabbing: x x x x  
 Numb / Tingling: o o o o  
 Pins & Needles: . . . .  
 Burning: = = = =  
 Throbbing: / / / /  
 Other Pain: - - - -



**Therapist Notes:**

PATIENT SIGNATURE / PREPARED BY:

DATE

DEPARTMENT/SERVICE/CLINIC

LRMC Physical Therapy  
 APO AE 09180 486-8263

PATIENTS IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical facility)

NAME (Last, First MI):

FMP / SSN (Sponsor): /

GRADE or RANK:

DOB:  
 (Patients, dd-mmm-yyyy)

- |  |  |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL                            | <input type="checkbox"/> FLOW CHART      |
| <input checked="" type="checkbox"/> OTHER/EXAMINATION OR EXAMINATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES                          |  |
| <input type="checkbox"/> TREATMENT                                   |  |

## Ankle Joint Functional Assessment Tool (AJFAT)

### **Section 1: To be completed by patient**

\_\_\_\_\_ AD      \_\_\_\_\_ Non-Active Duty

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

How long have you had ankle problems: \_\_\_\_\_

### **Section 2: To be completed by patient**

This questionnaire has been designed to give your therapist information as to how your ankle problems have affected your functional ability. Please answer every question by placing a check on the line that best describes your injured ankle compared with the non-injured side. Check only 1 answer for each question, choosing the answer that best describes your injured ankle. We realize you may feel that two of the statements may describe your condition, but **please check only the line which most closely describes your current condition.**

#### **1. How would you describe the level of pain you experience in your ankle?**

- \_\_\_\_\_ Much less than the other ankle
- \_\_\_\_\_ Slightly less than the other ankle
- \_\_\_\_\_ Equal in amount to the other ankle
- \_\_\_\_\_ Slightly more than the other ankle
- \_\_\_\_\_ Much more than the other ankle

#### **2. How would you describe any swelling in your ankle?**

- \_\_\_\_\_ Much less than the other ankle
- \_\_\_\_\_ Slightly less than the other ankle
- \_\_\_\_\_ Equal in amount to the other ankle
- \_\_\_\_\_ Slightly more than the other ankle
- \_\_\_\_\_ Much more than the other ankle

#### **3. How would you describe the ability of your ankle when walking on uneven surfaces?**

- \_\_\_\_\_ Much less than the other ankle
- \_\_\_\_\_ Slightly less than the other ankle
- \_\_\_\_\_ Equal in ability to the other ankle
- \_\_\_\_\_ Slightly more than the other ankle
- \_\_\_\_\_ Much more than the other ankle

#### **4. How would you describe the overall feeling of stability of your ankle?**

- \_\_\_\_\_ Much less stable than the other ankle
- \_\_\_\_\_ Slightly less stable than the other ankle
- \_\_\_\_\_ Equal in stability to the other ankle
- \_\_\_\_\_ Slightly more stable than the other ankle
- \_\_\_\_\_ Much more stable than the other ankle

#### **5. How would you describe the overall feeling of strength of your ankle?**

- \_\_\_\_\_ Much less strong than the other ankle
- \_\_\_\_\_ Slightly less strong than the other ankle
- \_\_\_\_\_ Equal in strength to the other ankle
- \_\_\_\_\_ Slightly stronger than the other ankle
- \_\_\_\_\_ Much stronger than the other ankle

#### **6. How would you describe your ankle's ability when you descend stairs?**

- \_\_\_\_\_ Much less than the other ankle
- \_\_\_\_\_ Slightly less than the other ankle
- \_\_\_\_\_ Equal in amount to the other ankle
- \_\_\_\_\_ Slightly more than the other ankle
- \_\_\_\_\_ Much more than the other ankle

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**Section 2 (con't): To be completed by patient**

**7. How would you describe your ankle's ability when you jog?**

- Much less than the other ankle
- Slightly less than the other ankle
- Equal in amount to the other ankle
- Slightly more than the other ankle
- Much more than the other ankle

**8. How would you describe your ankle's ability to "cut," or change directions, when running?**

- Much less than the other ankle
- Slightly less than the other ankle
- Equal in amount to the other ankle
- Slightly more than the other ankle
- Much more than the other ankle

**9. How would you describe the overall activity level of your ankle?**

- Much less than the other ankle
- Slightly less than the other ankle
- Equal in amount to the other ankle
- Slightly more than the other ankle
- Much more than the other ankle

**10. Which statement best describes your ability to sense your ankle beginning to "roll over"?**

- Much later than the other ankle
- Slightly later than the other ankle
- At the same time as the other ankle
- Slightly sooner than the other ankle
- Much sooner than the other ankle

**11. Compared with the other ankle, which statement best describes your ability to respond to your ankle beginning to "roll over"?**

- Much later than the other ankle
- Slightly later than the other ankle
- At the same time as the other ankle
- Slightly sooner than the other ankle
- Much sooner than the other ankle

**12. Following a typical incident of your ankle "rolling," which statement best describes the time required to return to activity?**

- More than 2 days
- 1 to 2 days
- More than 1 hour and less than 1 day
- 15 minutes to 1 hour
- Almost immediately

**Section 3: To be completed by physical therapist/provider**

**SCORE:** \_\_\_\_\_ out of 48 possible points (higher better)    **Initial**      **2 weeks**      **Discharge**

**Number of treatment sessions:** \_\_\_\_\_      **Gender:**      Male      Female

**Diagnosis/ICD-9 Code:** \_\_\_\_\_

<sup>1</sup> Adapted from: Rozzi SL, et al. Balance Training for Persons With Functionally Unstable Ankles. JOSPT 1999; 29 (8): 478-486 [Prepared July 1999]