

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 Foot 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:

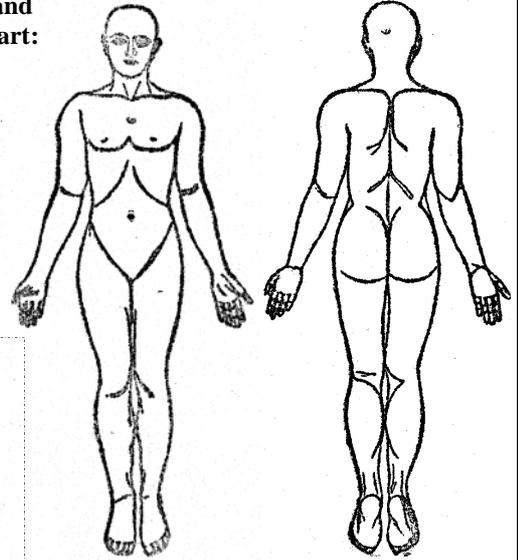
Change in your general health?	Yes	No
Fever / chills / sweats?	Yes	No
Unexplained weight change (>10lbs)?	Yes	No
Numbness or tingling?	Yes	No
Bowel / bladder incontinence?	Yes	No
Difficulty sleeping due to pain?	Yes	No
Unexplained Falls/Decreased balance?	Yes	No

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 | |

Foot Function Index¹

Section 1: To be completed by patient _____ AD _____ Non-Active Duty

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of days of foot pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in every day life. For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your foot **over the past WEEK**. Please read each question and place a number from 0-10 in the corresponding box.

Pain Scale: 0= No Pain 10=Worst Pain Imaginable

	1.	In the morning upon taking your first step?		
	2.	When walking?		
	3.	When standing?		
	4.	How is your pain at the end of the day?		
	5.	How severe is your pain at its worst?		

Answer all of the following questions related to your pain and activities **over the last WEEK**, how much difficulty did you have? **Disability Scale: 0= No Difficulty 10= So Difficult unable to do**

	6.	When walking in the house?		
	7.	When walking outside?		
	8.	When walking four blocks?		
	9.	When climbing stairs?		
	10.	When descending stairs?		
	11.	When standing tip toe?		
	12.	When getting up from a chair?		
	13.	When climbing curbs?		
	14.	When running or fast walking?		

Answer all the following questions related to your pain and activities **over the past WEEK**. How much of the time did you: **Disability Scale: 0= None of the time 10= All of the time**

	15.	Use an assistive device (cane, walker, crutches, etc) indoors?		
	16.	Use an assistive device (cane, walker, crutches, etc) outdoors?		
	17.	Limit physical activities?		

Section 3: To be completed by physical therapist/provider

SCORE: _____ /170 x100= _____ % (SEM 5, MDC 7) **Initial** **F/U at** _____ **wks** **Discharge**

Number of treatment sessions: _____ **Gender:** Male Female

Diagnosis/ICD-9 Code: _____

¹ Adapted from Budiman-Mak E, Conrad KJ, Roach K. The foot function index: A measure of foot pain and disability. J Clin Epidemiology. 4(6): 561-70, 91.