



GP THERAPY, LLC D.B.A.

# GERMANTOWN PHYSICAL THERAPY

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**Patient:** \_\_\_\_\_ **Region:** Ankle

1. Describe your pain (sharp, dull, radiating, etc) \_\_\_\_\_
2. When and how did it start? \_\_\_\_\_
3. What makes it better? Worse? \_\_\_\_\_
4. Have you had other treatment for this condition? If so, what kind? \_\_\_\_\_
5. Rate your average pain intensity over the past week on the 0 to 10 scale with 10 being the worst pain imaginable. \_\_\_\_/10
6. Average number of times you wake per night due to **ankle/foot** pain: \_\_\_\_\_
7. Standing tolerance is \_\_\_\_\_ minutes.
8. Walking tolerance is \_\_\_\_\_ minutes.
9. Are you using an assistive device such as a cane or crutches? \_\_\_\_\_

*For questions 10 through 19, circle the number that best describes your level of difficulty with the following activities. 0 indicates no difficulty, whereas 10 indicates the inability to perform the activity at all.*

	No Difficulty										Extreme Difficulty											
10. Driving a car	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
11. Getting in/out of car	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
12. Walking up stairs	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
13. Walking down stairs	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
14. Walking on uneven surfaces	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
15. Walking in raised heel shoes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
16. Stepping down from a curb	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
17. Squatting	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
18. Running	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
19. Jumping	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

20. What is your current occupation? \_\_\_\_\_
21. Does your pain affect your occupation? If so, how? \_\_\_\_\_  
\_\_\_\_\_
22. Does your pain affect home life? If so, how? \_\_\_\_\_  
\_\_\_\_\_
23. Does your pain affect your recreation/leisure/sports? If so, how? \_\_\_\_\_  
\_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date:        /        /