



**SILVERMAN**  
ANKLE & FOOT

## ANKLE AND FOOT HISTORY

NAME:

DATE:

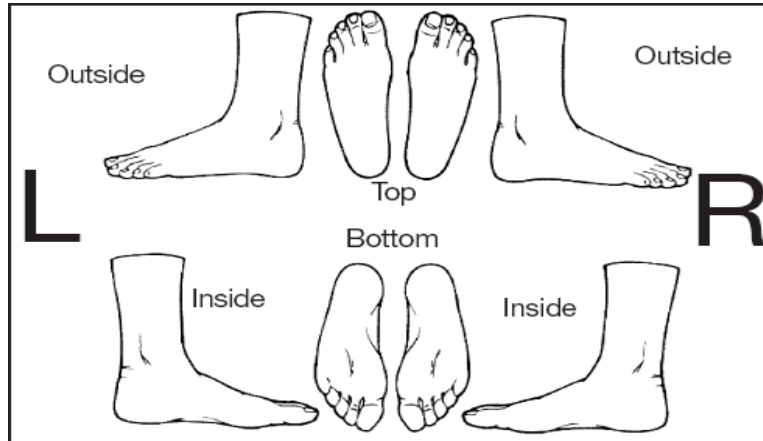
### WHERE IS YOUR PROBLEM?

(ex. Big toe, ankle, midfoot etc)

**RIGHT**  
**LEFT**

**MARK SPECIFICALLY WHERE  
YOUR PROBLEM IS WORST --->**

**PLEASE LIST AREAS OTHER THAN  
FOOT AND ANKLE THAT HURT:**



| CIRCLE ALL THAT APPLY  | X | WHICH IS MOST BOTHERSOME? |
|------------------------|---|---------------------------|
| Pain                   |   |                           |
| Tingling               |   |                           |
| Numbness               |   |                           |
| Warmth                 |   |                           |
| Redness                |   |                           |
| Deformity              |   |                           |
| Ulcer or Sore          |   |                           |
| Collapsing Arch        |   |                           |
| Catching               |   |                           |
| Grinding               |   |                           |
| Instability / Give way |   |                           |
| Limping                |   |                           |
| Locking                |   |                           |
| Weakness               |   |                           |
| Other                  |   |                           |
| Nothing definite       |   |                           |

**HOW LONG HAS THIS BOTHERED YOU:** \_\_\_\_\_ weeks / months / years

**INJURY DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**DESCRIPTION OF EVENTS LEADING UP TO THIS PROBLEM:**

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**The symptoms began:** Suddenly Intermittently Gradually  
**The symptoms are:** Constant Intermittent Predictable Unpredictable  
**The symptoms are worst:** Mornings During the day Starting after rest  
 Activity related End of the day Wakes from sleep Other:  
**The symptoms are:** Minor Moderate Severe  
**The symptoms are:** Improving Gradually / Rapidly worsening Unchanged

**HAVE YOU EVER EXPERIENCED A SIMILAR PROBLEM?**

**CIRCLE ALL THAT APPLY**

**DESCRIBE THE NATURE OF YOUR SYMPTOMS:**

Aching  
 Burning  
 Dull  
 Numbing  
 Pulling  
 Sharp  
 Shooting  
 Sore  
 Stabbing  
 Tearing  
 Throbbing  
 Other:

**WHAT AGGRAVATES YOUR SYMPTOMS?**

Direction changes  
 Jumping  
 Hard Stops  
 Quick Starts  
 Running  
 Standing  
 Sports  
 Walking  
 Walking Barefoot  
 Other activity:  
 Dress Shoes  
 Hard Surfaces  
 Uneven ground  
 Nothing definite  
 Other surface:

**WHAT IMPROVES YOUR SYMPTOMS?**

Rest  
 Walking Barefoot  
 Limping  
 Avoiding Sports  
 Wearing Shoes  
 Ice  
 Elevation  
 Stretching  
 Compressive Wrap  
 Shoe Modification  
 Shoe Inserts  
 Brace  
 Cast or Boot  
 Other:  
 Nothing definite  
 Medication:

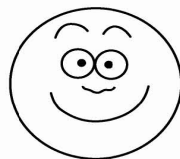
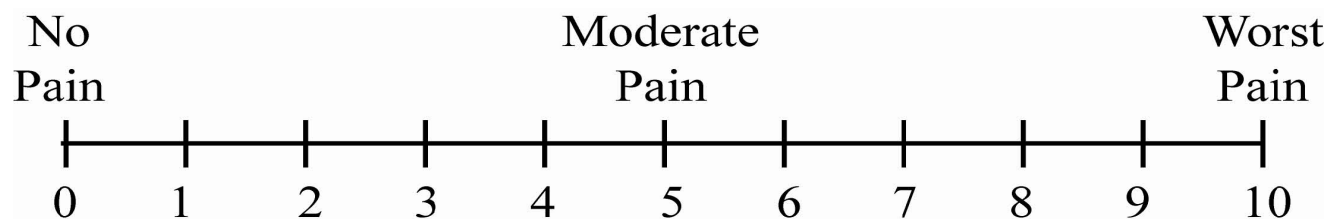
**WHAT PAST TREATMENTS HAVE YOU ATTEMPTED?**

Physical Therapy Medication Surgery, please describe:  
 Chiropractor (D.C.) Podiatrist (DPM)

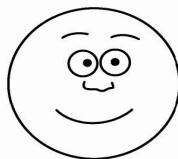
**WHAT TESTS HAVE BEEN ORDERED FOR THIS PROBLEM?**

XR MRI CT EMG/NCS Bone Scan

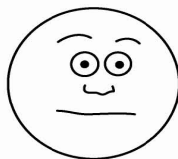
**WHEN?**



0



2



4



6



8



10

Circle the number or face to show where your pain intensity is located