New Foot/Ankle Intake Form

Name:__________________________________ **DOB:** ___________ **Date:**____

Employer:______________________________ **Current Occupation/Job**_____________________________________

Activities, Hobbies____

<u>Please Describe</u> Your Bone/Joint Problem, Which Side It Is On, And How We Can Help: ___________________________
____
____

Date Problem Began:____________________________ **Reported to employer?** **Yes** **No**

Result of Injury? **Yes** **No** **Involves a Legal Case?** **Yes** **No**

Happen at Work? **Yes** **No** **Date:**__________ **Have you worked Since?** **Yes** **No**

Last Day worked? ______________________________

<u>You</u> are here today with: Alone Spouse Parent Child Sibling Friend Relative Interpreter Case Manager

Normally live with: Alone Spouse Parent Child Sibling Friend Relative

<u>What</u> is your domicile status? House Apartment Rehab Center Nursing Home Assisted Living

Is your typical shoe-wear? Sneakers Sandals Heels Diabetic Wear SAS Loafers Dress Other

Current Work Status: Full Duty Light Duty Unemployed Retired Permanently Disabled

Weight Bearing Status on affected side: non touchdown partial full

Immobilization: none post-op shoe sleeve/stirrup boot splint toe protector cast AFO Custom Brace

Assistive device: none crutches walker wheelchair cane other

Driving Status: Yes No

Pain Location: ____

Level, currently (indicate on scale): (no pain) 0—1—2—3—4—5—6—7—8—9—10(worst pain imaginable)

Improves with: rest activity heat cold elevation massage shoe-wear removal NSAIDS nothing

Timing: during activity after activity never sometimes always standing sitting nighttime unpredictable

Description: sharp dull burning constant intermittent infrequent gradual sudden improving worsening

Do you Have Instability? Yes No

How Many Yards can you walk Without Stopping? ________ **With Stopping**? __________

You are currently able to: stand walk jog run jump climb cycle play sports wear shoes go outside

Have you EVER had any of the following treatments/tests for <u>THIS</u> problem (check all that apply):

_____Orthotics
_____Cast Immobilization
____Bracing (e.g., boot, stirrup, lace-up, splint, toe protector)
____Injection
____Physical Therapy
____PAST SURGERY: 1. Type:____________________________Date:____________Surgeon:_____________Helped?____
2. Type:____________________________Date:____________Surgeon:_____________Helped?____

____X-rays
____MRI
____Cat Scan
____EMG/Nerve Study
____Bone Scan

DX: ____ RX: _________________________________ XR/DATE: ____________________

Daniel Glenney, M.D.
Patricia Stuart, M.D.
Kenneth Paonessa, M.D.
Michael Halperin, M.D.
Gabriel Abella, M.D.
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Jonathan Piposar, M.D.
Emily Vafek, M.D.

Tammie Simao, CMPE, CEO

Date: ___________________________ Date of Injury: __________________

Patient: _________________________ Place of Injury: __________________

Provider: ________________________ Work Related? ____ Yes / _____ No

Account #: ____________________ Auto Accident: ____ Yes / _____ No

Insurance: ________________________ ID: ____________________________

Subscriber: ______________________

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy (this means the auto insurance pays as your primary insurance)

______ I have no Auto Med Pay Insurance (this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / ______ No

What did you injure? (example: left arm) ______________________________

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including <u>how</u> and <u>where</u> it occurred as required by your insurance:

____

____

____

Signature ____ Witnessed ___________________________