

NAME \_\_\_\_\_ DATE \_\_\_\_\_ DOB \_\_\_\_\_

**New Foot/Ankle Intake Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Current Occupation/Job \_\_\_\_\_

Activities, Hobbies \_\_\_\_\_

**Please Describe 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? \_\_\_\_\_

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

Normally live with: Alone Spouse Parent Child Sibling Friend Relative

What 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 THIS 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



**ORTHOPEDIC  
PARTNERS**  
Formerly Norwich Orthopedic Group  
EST. 1957

Patricia Stuart, M.D.

Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Kenneth Paonessa, M.D.

Patient: \_\_\_\_\_ Place of Injury: \_\_\_\_\_

Michael Halperin, M.D.

Provider: \_\_\_\_\_ Work Related? \_\_\_\_ Yes / \_\_\_\_ No

Gabriel Abella, M.D.

Account #: \_\_\_\_\_ Auto Accident: \_\_\_\_ Yes / \_\_\_\_ No

Mohammad Pasha, M.D.

Insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Tarik Kardestuncer, M.D.

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)

Ammar Anbari, M.D.

Nicole Arcand, M.D.

Are you pursuing legal action against another party? \_\_\_\_ Yes / \_\_\_\_ No

Scott Stanat, M.D.

What did you injure? (example: left arm) \_\_\_\_\_

Richard Thoms, M.D.

Steven Wei, M.D.

**Attention Pequot 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.

Jonathan Puposar, M.D.

**Please give a complete and accurate account of the injury, including how and where it occurred as required by your insurance:**

Emily Vafek, M.D.

\_\_\_\_\_  
\_\_\_\_\_

Nimit Patel, M.D.

Signature \_\_\_\_\_ Witnessed \_\_\_\_\_