

INITIAL FOOT/ANKLE EVALUATION

PATIENT: _____ AGE: _____

SS#: _____ DATE: _____

Check Normals Circle/Write Positives Backslash (\) Negatives

Onset/Duration: _____

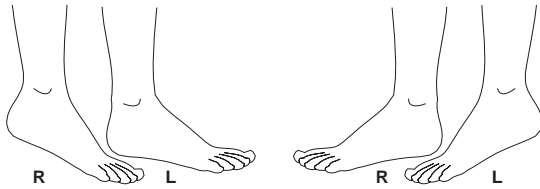
CC: _____

Consult Req By: _____

HPI/IMPAIRMENT: (1-2=1-3 ele / 3-5= \geq 4 ele or \geq 3 chronic cond)

Context: Fall / MVA / Twisting Injury / Arthritis / _____
 Work Related Not Work Related

Location:
 Shade or "X" Area



Quality:
 Dull / Sharp Stiffness Stabbing
 Numbness Throbbing/Pulling Sensation
 Tingling Burning Aching

Severity/Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Progression: stable / improving / worsening

Associated Signs/Symptoms:
 Difficulty Walking Difficulty Running Difficulty Playing Sports
 Foot Swelling Ankle Swelling
 Weakness Erythema Stiffness

Exacerbating Factors	Relieving Factors
Walking	Rest / Elevation
Footwear	Heat / Ice
Exercise	Meds: _____
Bare feet	Walking / Activity
Nothing	Nothing

Physicians Seen _____ - _____
 For This Condition: _____ - _____
 Medication Trial: _____ Helped / Did Not Help
 _____ Helped / Did Not Help
 Therapy: PT OT Aquatics Frequency: _____ x/week
 Helping Did Not Help Worsening
 Assistive Device: Crutches / Walker / RW / Quadcane / SC / WC
 Recent Hosp: _____ Date: _____
 Reason: _____

ROS:
Cons
 Fever / Chills / Fatigue
 Weight Change \uparrow \downarrow
 Sleep Disturbance
CVS
 Chest Pain / DOE
 Palpitations
Pulm
 SOB / Cough
GI
 Constipation / Diarrhea
 Incontinence
GU
 Urgency / Frequency
 Incontinence

Musc
 Joint / Muscle Pain
 Joint Stiffness
 Muscle Cramping
 Limited ROM
Neuro
 Muscle Spasms / Falls
 Burning / Tingling
Psych
 Depression / Anxiety
Skin
 Warmth / Coldness
 Erythema / Drainage
 Breakdown / Rash

 _____ All Other Systems Negative
 _____ Unable to Obtain 2nd to: _____

Eyes
 Glasses
 Double Vision
ENT
 HOH / Dizziness
Heme
 \uparrow Bruising
Lymph
 Swollen Glands

ROS filled out by patient (see form 1120) Reviewed by physician _____

PAST MEDICAL HISTORY:

Anemia	Fracture - _____	AKA - R / L BKA - R / L
Angina	GERD	Appendectomy
Arthritis	GI Bleed - Up / Low	CABG x _____
Asthma	Hypercholesterolemia	Carotid Endarterec- R/L
Atrial Fib	Hypertension	Cataract Removal
CAD	MI - _____	Cath - Angioplasty / Stent
Cancer - _____	Obesity	Cholecystectomy
CHF	Parkinson's Disease	Hysterectomy
COPD	Pneumonia	ORIF _____
CVA / TIA	PVD	Pacemaker Insertion
Depression	Renal Insuff	THR - R / L TKR - R / L
DM - I / II	Seizure Disorder	
DVT - RLE / LLE	Spinal Stenosis	
ESRD		

CURRENT MEDICATIONS: Reviewed in Chart

OTC Meds/Herbals: _____

ALLERGIES: NKDA

SOCIAL HISTORY:

Lives: With Spouse With Son / Daughter Alone _____
 Assisted Living Facility Nursing Home
 _____ Level House / Apartment / Townhouse / Mobile Home
 _____ Steps Ramp / Elevator / 1st Floor Setup / Rails - R / L / Bi

Occupation: _____ Working Light Duty Retired Disabled
 Unable to Work Since: _____ Returned to Work: _____

Tobacco _____ ppd x _____ years Quit: _____
 ETOH socially / daily Quit: _____
 Illicit Drugs _____ Quit: _____

FAMILY HISTORY: Not Significant For: _____
Family Member History Of

PFSH filled out by patient (see form 1120) Reviewed by physician _____

*History Obtained From: Patient / Family / Caregiver / _____

Patient: _____ Date: _____

PHYSICAL EXAM: (1=1-5 ele / 2= \geq 6 ele / 3= \geq 12 ele / 4-5= \geq 18 ele)

Vitals: Weight: _____ Height: _____ Pulse: _____

Gen App: ___ WDNW Obese Thin Frail _____

Musc/ ___ Gait/Stance WNL Limp - R / L Antalgic

Knee ___ No Deformity BLE _____

Exam: ___ ROM WFL BLE See Below

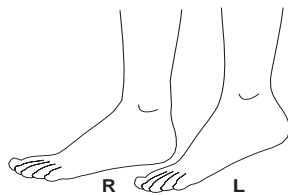
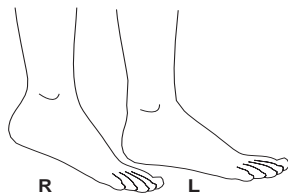
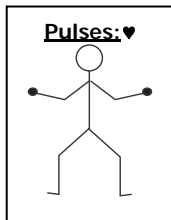
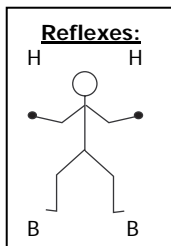
___ Strength WFL BLE See Below

___ No Musc Atrophy BLE _____

___ Tone NI BLE R: _____ L: _____

Strength:	Right	Left	Testing:	Right	Left
EHL	_____	_____	Single Heel Rise	_____	_____
Tibialis Ant	_____	_____	Evertor Weakness	_____	_____
Plantar Flex	_____	_____	Lateral Lig Tender	_____	_____
Dorsiflexors	_____	_____	Deltoid Tender	_____	_____
Evertors	_____	_____	Posterior Tib Tend	_____	_____
Invertors	_____	_____	Thompson's Test	_____	_____
Post Tibials	_____	_____			

ROM:	Right	Left
Ankle	<input type="checkbox"/> Full ROM	<input type="checkbox"/> Full ROM
DF	_____	_____
PF	_____	_____
Sublat Jt	<input type="checkbox"/> Full ROM	<input type="checkbox"/> Full ROM
1 st	_____	_____
2 nd	_____	_____
3 rd	_____	_____
4 th	_____	_____
5 th	_____	_____



Neuro/ ___ Sensation WNL BLE See Diagram Above

Psych: ___ Coordination WNL R: _____ L: _____

___ Oriented x3 Confusion

___ Mood/Affect WNL Agitation / Anxious

Vasc:♥ ___ No Edema BLE R: _____ L: _____

___ No Calf Tenderness Tender: R / L / Bi

___ No Varicosities BLE R: _____ L: _____

___ Skin Temp WNL R: _____ L: _____

___ BLE Pulses Intact See Below

Skin: ___ No Lesions / Rashes BLE See Diagram on Left

___ No Ulcerations BLE See Diagram on Left

Lymph: ___ No Groin Lymphadenopathy _____

RADIOLOGY REVIEWED: See Assoc Reports & Films

MRI: Film(s) Report(s) Date: _____

Other X-Ray: Film(s) Report(s) Date: _____

LABORATORY REVIEWED: Date: _____

MEDICAL TESTS REVIEWED: Therapy Notes Reviewed

Date: _____

Review Old Records &/or Discuss w/Other Health Care Provider
Discussed with: _____

IMPRESSION:

Lateral Ankle Sprain – grade _____ stable / imp / worse
 Medial Ankle Sprain – grade _____ stable / imp / worse
 Posterior Tibial Tenderness _____ stable / imp / worse
 Posterior Tibial Rupture _____ stable / imp / worse
 Achilles Tendonitis _____ stable / imp / worse
 Achilles Tendon Rupture _____ stable / imp / worse
 Avulsion 5th Metatarsal _____ stable / imp / worse
 Jones Fracture _____ stable / imp / worse
 Ankle Fracture _____ stable / imp / worse
 Hallux Rigidus (1st MTP) _____ stable / imp / worse
 Hallux Valgus (Bunion) 1st MTP _____ stable / imp / worse
 Bunionette (5th MTP) _____ stable / imp / worse
 Other Fractures: _____ stable / imp / worse

PLAN:

Discussion/To Consider: _____
 *Records Ordered: _____
 *Medication Trial: _____
 *Refill/Continue Meds: _____
 *Therapy RX / Continue: PT OT Aquatics _____
 Exercises: _____
 *Radiology/Labs/Tests: _____
 Injected with 4cc Lidocaine & 1 cc Depo-Medrol under sterile conditions
 Ice Brace Other: _____
 Ref to Dr. / FU with: _____ Letter Dictated
 Work Slip Given: Off Work Thru: _____
 Light Duty Moderate Duty Return to Work
 RTO: _____ Weeks / Months PRN

CRNP/PA-C Signature

Physician Signature

Discussed w/Physician Pt Seen By Physician Addendum Dictated

Visit Time: Time Began: _____ Time Ended: _____

>50% of Time Spent Counseling Pt On: Test Results / Therapy /
Meds / Activity / Diagnosis / Prognosis / _____

cc: _____

Resp: ___ CTA Wheezing Rhonchi Rales
 ___ Resp Unlabored Respiratory Distress

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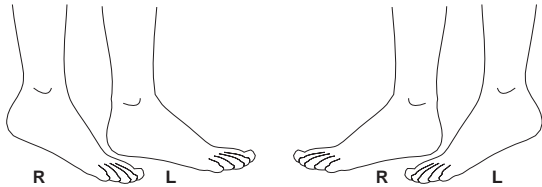
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- | | | |
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- Footwear
- Exercise
- Bare feet
- Nothing

Relieving Factors

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- Heat / Ice
- Meds: _____
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- Nothing

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 _____ - _____

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 Reason: _____

ROS as noted in "Patient History Form". Reviewed by physician _____

PERTINENT POSITIVES: _____

*History Obtained From: Patient / Family / Caregiver / _____

NOTES: _____

CURRENT MEDICATIONS:

Medications as noted in "Medication Form". Reviewed by physician _____

OTC Meds/Herbals:

ALLERGIES: NKDA

PAST/FAMILY/SOCIAL HISTORY:

PFSH as noted "Patient History Form". Reviewed by physician _____