Lower Extremity Evaluation

Name:_____ **DOB:**_____/_____/_____ **Today's Date:**_____/_____/_____

Reason for visit: ☐Hip ☐Knee ☐Ankle ☐Foot ☐ Toe ☐Other:_____

Side: ☐Left ☐Right ☐Both **Date of injury/Symptoms:** _____/_____/_____

Is this problem related to an injury? ☐Yes ☐No Motor vehicle accident? ☐ work related injury? ☐ sports related injury? ☐

Describe how the injury occurred: _____

_____

Have you had surgery on this body part? _____ If yes, Procedure and Date:_____

Onset: ☐Sudden ☐Gradual **Duration:** How long have you had this problem:#_____☐Hours ☐Days ☐Weeks ☐Months ☐Years

Pattern: ☐Constant ☐ Intermittent ☐Persistent **Course:** ☐Improving ☐Worsening ☐Recurrent ☐Without Change

Functional Limitations: ☐None Difficulty with: ☐Getting in/out of car ☐ Arising from chair ☐Donning shoes & socks

Location:	**Pain:**	**Characterized As:**		**Associated Features:**	
☐ Front	☐ 0 - none	☐ Sharp	☐ Dull	☐ Swelling	☐ Loss of Motion
☐ Back	☐ 1	☐ Aching	☐ Throbbing	☐ Stiffness	☐ Painful Motion
☐ Inside	☐ 2	☐ Cramping	☐ Stabbing	☐ Popping	☐ Dislocation
☐ Outside	☐ 3	☐ Night Pain	☐ Burning	☐ Grinding	☐ Catching
☐ Thigh ☐Calf	☐ 4	☐ Numbness	☐ Shooting	☐ Instability	☐ Limping
☐ Entire Joint	☐ 5 - moderate	☐ Tightness	☐ Piercing	☐ Weakness	☐ Warmth
	☐ 6				
	☐ 7				
	☐ 8				
	☐ 9				
	☐ 10 - severe				

Aggravated by:		**Relieved by:**		**Physical Therapy For this injury?**	**Use of Assisted devices:**
☐ Nothing	☐ Squatting	☐ Nothing	☐ Massage	☐ Yes	☐ None
☐ Walking	☐ Prolonged Standing	☐ Rest	☐ Modified Activity	☐ No	☐ Bracing
☐ Running	☐ Physical Activities	☐ Lying Down	☐ Physical Therapy	When?_____	☐ Cane
☐ Kneeling	☐ Sports Activities	☐ Ice	☐ Medication	Where?_____	☐ Crutches
☐ Bending	☐ Work Activities	☐ Heat	☐ Bracing	_____	☐ Walker
☐ Sitting	☐ Climbing Stairs	☐ Exercise	☐ Cortisone Injections		☐ Wheelchair

Previous Diagnostic Tests: ☐X-ray ☐MRI ☐CT Scan ☐Arthrogram ☐Bone scan ☐EMG/NCS

***Where was it taken?:** _____

Review of Symptoms

Please check all that apply:

General:	**Cardiovascular:**	**Musculoskeletal:**	**Neurological:**
☐ Feeling Well	☐ Chest Pain	☐ Joint Swelling	☐ Dizziness
☐ Fever	☐ Palpitations	☐ Joint Pain	☐ Unsteadiness
☐ Chills	☐ Leg Swelling	☐ Joint Stiffness	☐ Weakness
☐ Fatigue		☐ Muscle Weakness	☐ Numbness
	Gastrointestinal:	☐ Muscle Pain	☐ Unusual Sensation
Skin:	☐ Heartburn/Reflux	☐ Muscle Atrophy	☐ Fainting
☐ Bruising	☐ Constipation	☐ Leg Cramps	☐ Headaches
☐ Rash	☐ Nausea		
Respiratory:	**Psychiatric:**	**Hematology:**	**Geniourinary:**
☐ Cough	☐ Anxiety	☐ Calf Pain	☐ Painful Urination
☐ Wheezing	☐ Depression	☐ Blood Clots	☐ Incontinence
☐ Difficulty Breathing	☐ Insomnia	☐ Nose Bleeds	☐ Difficulty Urinating

Patient Signature:_____**Date**_____/_____/_____

Physician Signature:_____**Date**_____/_____/_____

Pro Sports Orthopedics, Inc