ADRIANA STRIMBU, DPM, PA
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Name:_____Phone:_____ Age:_____

Please check any of the following conditions you are currently experiencing or suffering from:

- □Flat Feet
- □Poor Coordination
- □Heel or Arch Pain
- □Leg pain(shin splints)
- □Achilles tendon pain
- □Discoloration of toes/foot
- □Ankle swelling or stiffness
- □Pain in feet or legs with exercise
- □Foot/Toes/Legs Burn
- □Pain in feet getting out of bed
- □"Toe-in"or "Toe-out" gait (walking)
- □ Pain or fatique of feet or legs in activity
- □Ankle instability (easy twisting injuries)
- □Difficulty/Pain with brisk walking or running
- □ Pain in legs occurs at the same distance every time
- □Coldness in the legs or feet that is uncomfortable
- □Non/ Poor healing sore on the leg or foot
- □Feet/Toes feel numb

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living?Yes / No

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:	Pain radiating into:	Weakness of the:	Difficulty with:
□Legs R / L	□Ankle R / L	□ Legs R / L	□ Standing
□Ankle R / L	□Feet R / L	□Ankle R /L	□ Walking
□Feet R / L	□Toes R / L	□Foot R / L	□Sitting
			□Bending
			□ Lifting
			□Kneeling

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? Yes / No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

□I would like to discuss the above conditions with the doctor so I can make an educated decision about my health.
□If it were available, I would be interested in receiving treatment for this condition in this office.
□If available, I would be open to have a medical test to further evaluate my problem.
Patient's Signature:_____ Date:_____