

## Lower Extremity Evaluation

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit:  Hip  Knee  Ankle  Foot  Toe  Other: \_\_\_\_\_

Have you had surgery on this body part? \_\_\_\_\_ If Yes, Procedure and Date \_\_\_\_\_

Side:  Left  Right  Both Date of injury/Symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this a work related injury?  Yes  No Explain: \_\_\_\_\_

Is this a result of a motor vehicle accident?  Yes  No Explain: \_\_\_\_\_

Is this a sports related injury?  Yes  No Explain: \_\_\_\_\_

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:	Severity of Pain:	Characterized As:	Associated Features:
<input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Entire Joint	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cramping <input type="checkbox"/> Night Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tightness	<input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Stabbing <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Piercing <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Popping <input type="checkbox"/> Grinding <input type="checkbox"/> Instability <input type="checkbox"/> Weakness <input type="checkbox"/> Loss of Motion <input type="checkbox"/> Painful Motion <input type="checkbox"/> Dislocation <input type="checkbox"/> Catching <input type="checkbox"/> Limping <input type="checkbox"/> Warmth

Aggravated by:	Relieved by:	Have you had prior Physical Therapy	Use of Assisted devices:
<input type="checkbox"/> Nothing <input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Kneeling <input type="checkbox"/> Bending <input type="checkbox"/> Sitting <input type="checkbox"/> Squatting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Physical Activities <input type="checkbox"/> Sports Activities <input type="checkbox"/> Work Activities <input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Lying Down <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Exercise <input type="checkbox"/> Massage <input type="checkbox"/> Modified Activity <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Medication <input type="checkbox"/> Bracing <input type="checkbox"/> Cortisone Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No When? _____ Where? _____	<input type="checkbox"/> None <input type="checkbox"/> Bracing <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> 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:
<input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue  <b>Skin:</b> <input type="checkbox"/> Bruising <input type="checkbox"/> Rash  <b>Respiratory:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema <input type="checkbox"/> Phlebitis  <b>Gastrointestinal:</b> <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation  <b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Dementia	<input type="checkbox"/> Calf Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Leg Cramps  <b>Hematology:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches  <b>Geniourinary:</b> <input type="checkbox"/> Recurrent Urinary Infection <input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Prostate Cancer

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_