

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

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

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: <input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue Skin: <input type="checkbox"/> Bruising <input type="checkbox"/> Rash Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	Cardiovascular: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg Swelling Gastrointestinal: <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea Psychiatric: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia	Musculoskeletal: <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 Hematology: <input type="checkbox"/> Calf Pain <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	Neurological: <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 Geniourinary: <input type="checkbox"/> Painful Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Difficulty Urinating
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Patient Signature: _____ Date ____/____/____

Physician Signature: _____ Date ____/____/____

Pro Sports Orthopedics, Inc