Ronald K. Olm, D.P.M.

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Foot & Ankle Center, P.C.

Name:______________________________ Birthdate:___________Today's Date:_______________

Family Physician:________________________________ Are you a diabetic? ___Yes ___No

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 fatigue 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 everytime
___Coldness in the legs or feet that is uncomfortable
___Non/Poor healing sore on 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 Both	__Ankle R / L Both	__Legs R / L Both	__Standing
__Ankle R / L Both	__Feet R / L Both	__Ankle R / L Both	__Walking
__Feet R / L Both	__Toes R / L Both	__Foot R / L Both	__Sitting
			__Bending
			__Lifting
			__Kneeling

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

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 at your first visit.

___I would like to first only discuss the above conditions with the doctor so that I can make an educated decision about my health before receiving treatment.

___If time is available; I would like to receive treatment for my condition at my first office visit.

___I am open to having additional testing performed by another specialist if necessary to treat my condition.

_______________________________ _______________________
Patient or Guardian Signature Date

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