Springfield Orthopaedic & Sports Medicine Institute

Lower Extremity Assessment

Patient Name:_____________________________________ _____________**Date:** ________________________________

Birth Date: ______________________________ **Occupation:** ____

INVOLVED EXTREMITY:

HIP KNEE ANKLE FOOT / RIGHT LEFT BOTH

Was there an injury? YES NO Date of Injury: ______________________________________

Were you injured at work? YES NO If not, where? _______________________________________

Describe what happened in detail:

____

____

____

Primary Care Doctor's Name ____

Who Referred You To Us? ____

Please Circle Answers Below

Additional information related to your lower extremity problem:

Quality: Aching Boring Pins/Needles Sharp Sore Stabbing Stinging Throbbing
Other: ____

Severity: Mild Moderate Severe

Rate the Pain: (No pain) 0----1----2----3----4----5----6----7----8----9----10 (Severe pain)

Does this pain affect your sleep? YES NO

Do you have: Radiating pain Numbness Tingling

Functional Impairment: Mild Mild-Moderate Moderate Severe/Disabling

Are you currently in pain? YES NO When did it start? Days_____ Weeks______ Months_____Years _____

Aggravating Factors: Climbing Stairs Running Squatting Sports Other ________________________________

Relieving Factors: Cold Heat Massage Other: ____

Joint Symptoms: Grinding Giving Away Instability Locking Looseness Loss of Motion Popping Swelling

Tender to Touch Other ____

Previous Treatment for this problem?: YES NO If so, what? _____________________________________

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** Dr. Thompson and Dr. Galluch are investors in Ohio Valley Surgical Hospital. At times they refer patients to Ohio Valley Surgical Hospital in connection with their care and treatment.*

Revised 1/13 2/13 5/13 kseifrit