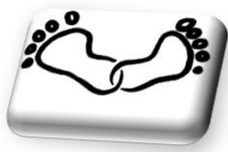


WAFL, Inc.

Brock A. Liden, D.P.M.

Circleville office
210 Sharon Road, Suite A
Circleville, OH 43113
Phone (740) 474-3850
Fax (888) 821-9123

Please send all correspondence to
PO Box 693, Pickerington, OH 43147

PODIATRY HISTORY FORM

Patient Name:____________________________ **Date of Birth:** _______________ **Date:** ________________

Current Problem

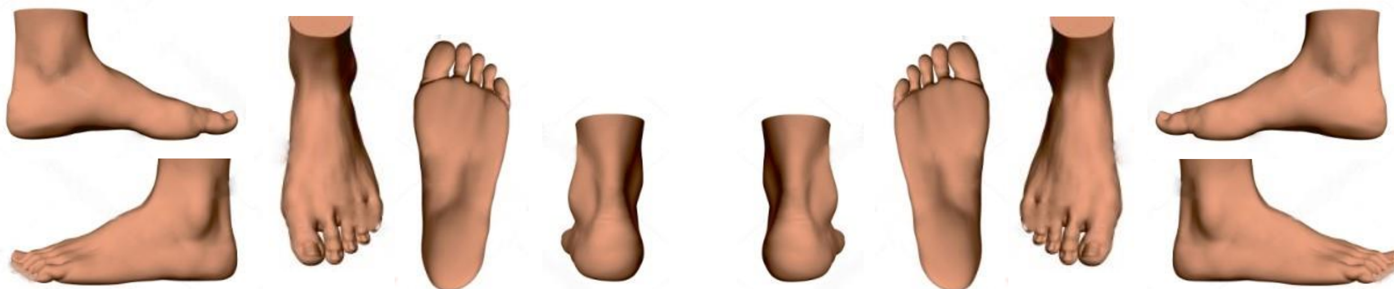
What specific problem(s) are we seeing you for today?

Problem 1:____

Problem 2:____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot **Right Foot**



How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How long ago did this problem first start?____

Did your pain or problem: ☐ Begin all of the sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching
☐ Stabbing ☐ Other ____

How would you rate your pain on a scale from 0 to 10? (Please Circle)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the last time your pain/problem began, has it: ☐ Stayed the same ☐ Become Worse ☐ Improved

What makes your pain/problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes ☐ High Heels
☐ Flat Shoes ☐ Any Closed Toe Shoe ☐ Running ☐ Other ____

What makes your pain/problem feel better?____

What treatments have you had for this problem?____

How has this problem affected your lifestyle or ability to work?____

Was this problem caused by an injury? ☐ Yes (Describe)____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No