Dr. Mitchell Tarka
P# (314) 900.0558 **F #** (888) 699.9987

MOTIONORTHOPAEDICS

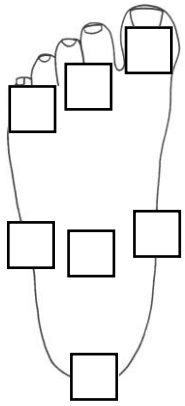
PATIENT NAME: _____ **DATE OF BIRTH:**

CURRENT PROBLEM

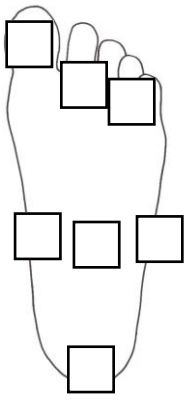
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

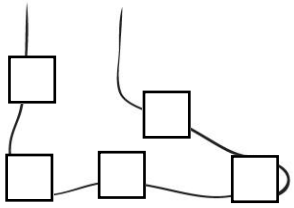
LEFT FOOT



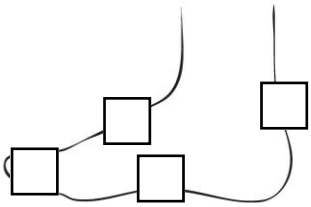
TOP OF FOOT



BOTTOM OF FOOT

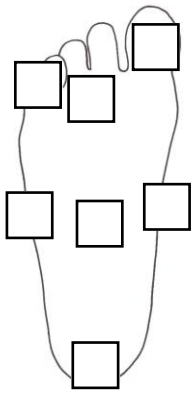


INSIDE OF FOOT

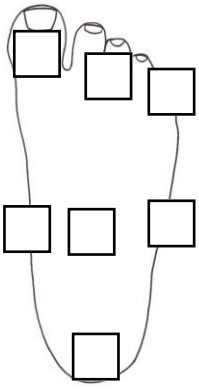


OUTSIDE OF FOOT

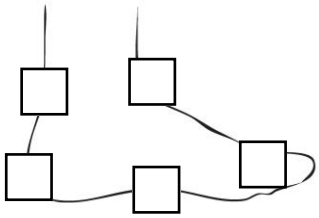
RIGHT FOOT



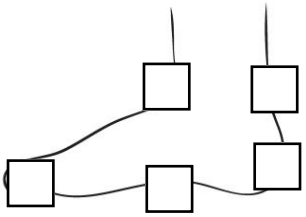
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A 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 Indicate the number _____
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (*Worst Pain Possible*)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR 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