NEW PATIENT QUESTIONNAIRE

Name: **Date of Birth:** D/M/YEAR

Today's Date: D/M/YEAR

Address:

Telephone: **Email:**

Doctors Name: **Referral Source:**

Address: Please sign: _____

MEDICAL HISTORY

Do you or any member of your family have a history of any of the following conditions: (Please tick)

CONDITION	YES	NO	DETAILS:
Anaemia	☐	☐	
Eczema/Psoriasis	☐	☐	
Peripheral vascular disease	☐	☐	
Varicose veins	☐	☐	
Blood clot (thrombosis)	☐	☐	
Pulmonary Embolism	☐	☐	
Stroke	☐	☐	
High Blood Pressure	☐	☐	
Angina	☐	☐	
Asthma	☐	☐	
Bronchitis/Emphysema	☐	☐	
Stomach Ulcer/Dyspepsia	☐	☐	
Reduced sensation in the feet/legs	☐	☐	
Disc Problems	☐	☐	
Back Ache	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid Arthritis	☐	☐	
Psoriatic Arthritis	☐	☐	
Diabetes	☐	☐	
Thyroid Dysfunction	☐	☐	
Other (Please list):			

Please list any operations you have had:

Please list any tablets that are prescribed for you:

Does your occupation involve periods of standing or walking: Yes ☐ No ☐

Please describe your current problem/complaint:

When did you first notice the problem (approximately)?

What was the initial cause of the problem (approximately)?

Have you seen any of the following?

Chiropodist :	**Yes** ☐	No ☐	Osteopath:	**Yes** ☐	No ☐
Chiropractor:	**Yes** ☐	No ☐	Podiatrist:	**Yes** ☐	No ☐
GP :	**Yes** ☐	No ☐	Physiotherapist:	**Yes** ☐	No ☐

Hospital Specialist (please list the specialty e.g. Orthopaedics, Rheumatologist etc.)

Please list the order in which you have seen these practitioners, the treatment provided and whether the treatment helped. (Each practitioner can be listed more than once if you returned following a consultation with someone else. Please continue on a separate sheet if necessary.)

	Practitioner	Treatment	Helpful (yes/no)	Approx. Date
1.				
2.				
3.				
4.				

Please describe your pain (dull ache, ache, throb, sharp stinging, pins and needles, burning)

Which of the following apply to your problem (tick as many as necessary)

- ☐ Occurs first thing in the morning
- ☐ Occurs on walking short distances
- ☐ Occurs on walking long distances
- ☐ Occurs on running
- ☐ Occurs in the evening
- ☐ Present all the time
- ☐ Goes quickly on rest
- ☐ Occurs in bed at night
- ☐ Wakes you at night
- ☐ On walking after a period of rest
- ☐ Going up stairs
- ☐ Going down stairs
- ☐ Takes a while to on rest
- ☐ Other (please list):

How often does it occur?

Daily ☐ 2-3 times per week ☐ Every other week ☐ 3-4 times a month ☐
5-10 times per month ☐ Less often ☐ Other: (Please detail)

What makes your problem worse?

What makes it easier?

Please mark on the scale below the degree of discomfort you experience (please circle). If your pain varies between activities circle more than one score and indicate activity.

No pain *Severe pain*

0 1 2 3 4 5 6 7 8 9 10

What weight are you approximately? **What is your Shoe size?**

Which of the following shoe types do you wear? If you wear trainers, please list these under sports shoes:

- ☐ Lace ups, heel height less than ½ inch
- ☐ Lace ups, heel height less than 1 inch
- ☐ Lace ups, heel height more than one inch
- ☐ Sandal, Sling back
- ☐ Sandal, Adjustable
- ☐ Slip ons, heel height less than ½ inch
- ☐ Slip ons, heel height less than 1 inch
- ☐ Slip ons, heel height more than 1 inch
- ☐ Sandal, Slip on
- ☐ Other: (Please specify)

In which of the following sports/activities do you participate (tick as many as appropriate):

	Level (Professional/ elite, amateur, hobby)	***Frequency (Times per week/ month / year)***
☐ Aerobics		
☐ High impact ☐ Step		
☐ Athletics (please detail)		
☐ Sprinting		
☐ Middle distance		
☐ Long distance		
☐ Field		
☐ Other		
☐ Badminton		
☐ Basketball		
☐ Cricket		
☐ Football		
☐ Golf		
☐ Gym		
☐ Weights		
☐ Treadmill ☐ Cycle / step / row		
☐ Hockey		
☐ Netball		
☐ Rugby		
☐ Sailing		
☐ Skiing		
☐ Squash		
☐ Tennis		
☐ Walking		
☐ Other: (please detail)		