Office Visit

Patient Name: _____ Date of Visit: _____/_____/_____

Explain your reason for seeing the doctor today: _____

_____

If you've had changes in your medical history such as medications, hospitalizations, or illness, please notify us.

Is the problem the result of an accident or injury? ☐ No ☐ Yes, explain _____

Have you had prior injuries or surgeries? ☐ No ☐ Yes _____

Have you seen another doctor for this condition? ☐ No ☐ Yes, who? _____

What diagnosis and treatment were given? _____

Is the problem present: ☐ all of the time ☐ some of the time ☐ comes and goes

How long have you had the symptoms? _____

Is the pain associated with a certain situation? _____

☐ Standing ☐ Walking ☐ Sports ☐ Getting up in morning ☐ Keeps awake at night ☐ Specific shoes ☐ Running

Does anything make the symptoms better? _____

Does anything make the symptoms worse? _____

Do you particiapte in: ☐ Walking ☐ Running ☐ Baseball ☐ Basketball ☐ Soccer ☐ Hockey ☐ Football ☐ Golf ☐ Dance ☐ Volleyball ☐ Gymnastics ☐ Biking ☐ Track ☐ Cross Country ☐ Marathons ☐ Triathalons Other _____

On what level? ☐ Occasional ☐ For Exercise ☐ For Competition ☐ School Team ☐ College ☐ Professional

Are you currently training for a special competition? ☐ No ☐ Yes _____

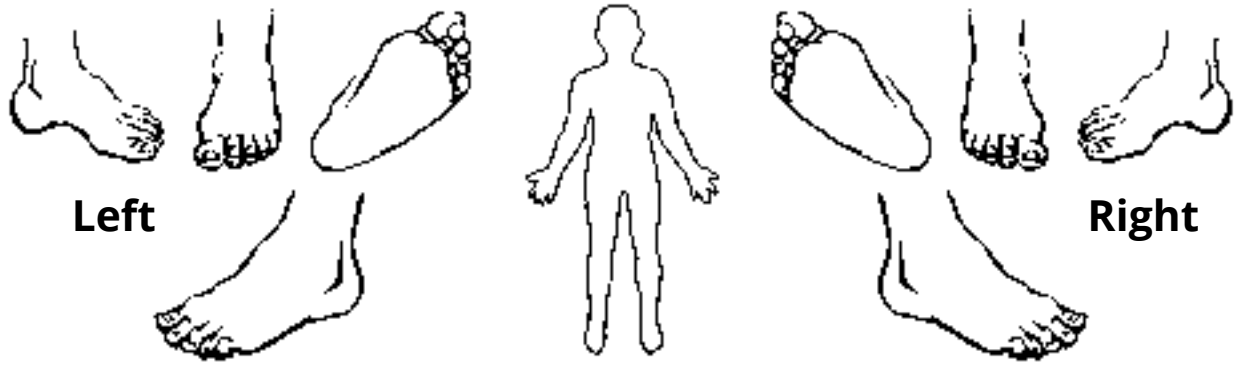
What kind of shoes do you wear for everyday? _____ Sports? _____

Do you wear orthotics? ☐ No ☐ Yes, from where? _____ What kind? _____

Circle the pain you're having: ☐ Burning ☐ Throbbing ☐ Aching ☐ Gnawing ☐ Stabbing ☐ Shooting ☐ Numbness

How severe is the pain? ☐ Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Severe

Mark the location of your problem:



I have answered all of the above questions truthfully and give Dr. Paul Coffin permission to diagnose and treat my condition. I authorize release of information needed to process insurance claims and authorize payment to Dr. Coffin.

_____ **Patient Signature (parent if minor)** Date _____