FOOT AND ANKLE PAIN DATA COLLECTION FORM

Initial Exam date: 
Date of Onset: 
Involved Side: 
Sex: 
Age (yrs): 
Height (in): 
Weight (lbs): 
Pt. record/ Pt. report

Diagnosis (check all that apply)
- Plantar Fasciitis/Fasciosis
- Tarsal Tunnel Syndrome
- Cuboid Syndrome
- Heel Spur or Heel Pain
- Achilles Tendinitis/opathy
- Inversion Ankle Sprain
- Post-surgical
- Eversion Ankle Sprain
- Other: ______________________

Procedure: ____________________  Date: 

Comorbidities:
- CVD (Patient/ Family History)
- CV Meds (including BP meds)
- DM (Patient/ Family History)
- DM Meds
- Pulmonary D/O.(Patient/Family History)
- Pulmonary D/O Meds
- Other Conditions

Balance Assessments:
- Degree of Patient perceived balance problem? (0=none, 10=maximal): 
- Balance Problem Treated? 

INTERVENTIONS & OUTCOMES

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<td>W. Other (specify):</td>
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<td>X. Other (specify):</td>
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Interventions Chosen by: 

Date of First Visit: 
Date of Last Visit: 
Patient Discharged? 

Foot and Ankle Pain Form (revised 8/08)-mdbs
Demographic Data

Dates: For all dates, use the format MM / DD / YYYY with a "0" in the first box if the month or day is a single digit. For the “date of symptom onset,” if the patient cannot recall an exact or approximate onset, use the first day of the month when the symptoms began. If the patient cannot recall the month, use 01 / 01 / YYYY.

Weight/Height: Fill in the patient’s weight and height with their shoes off, measured in pounds and feet/inches, respectively. If you are unable to measure the patient’s weight and/or height, leave this area blank.

Sex: Shade in the appropriate circle.

Involved Side: Shade in the appropriate circle, if both feet are involved, check the 'bilateral' category and also check the box for the LE that you are recording measurements for. For example, if the patient has bilateral foot and/or ankle symptoms, and you decide to record data for the left foot, then you would check both bilateral and left.

Diagnosis: Check any diagnosis that applies to the patient. More than one option may be selected. If the patient has had surgery for the condition, indicate the type of procedure and date.

Co-Morbidities: Check all co-morbidities that apply to the patient. More than one option may be selected. If the patient has other co-morbidities than the types given, please check other and list them in the space provided.

Medications taken for any co-morbidities: Check boxes of the co-morbidities that the patient is currently taking medication for.

Clinical Data

The data is set up to record at weekly intervals for the first six weeks of therapy (initial, 5 follow-ups, and discharge). Each row of data represents a given week. If the patient is seen somewhere in the interval, round up to the higher week number. If the patient is not seen during a given week, leave that row empty and fill in all other available data. If the patient is seen twice or three times in one week, use the latest visit in the data for that week. If both LE are involved, use the data from the more involved foot and ankle.

Treatments: For each week, choose from the list labeled A-x, the four major treatments used during that week. When more than four of the treatments are used, list the four of highest priority according to the therapist's opinion of those treatments that have most influence on the patient's recovery. Use the 'other' category to identify interventions that are not list, then list the intervention in the space provided.

Interventions Chosen By: Please indicate who selected the interventions or if it was a combined effort.

Ankle dorsiflexion passive range of motion (DF PROM): Position the patient in supine with the legs fully extended. While keeping the patient's ankle in subtalar neutral passively dorsiflex the patient's ankle through the maximum range of ankle dorsiflexion. Align the stationary arm of the goniometer with the fibular head and the moving arm parallel to the lateral order of the calcaneus. The PROM value is recorded as positive (+) when the ROM is beyond neutral (0 degrees). Record the value as a negative (-) when the ROM does not reach neutral. The appropriate sign should be placed in the first space followed by the range of motion on the goniometer.

Great toe MTP Extension (Ext) PROM: With the ankle maintained in neutral, passively extend the patient's great toe through the maximum range of available motion. Align the stationary arm with the midline of the first metatarsal. Align the moving arm with the midline of the proximal phalanx of the great toe. Record the value as described for ankle DF PROM.

Pain Score at Worst: Ask the patient to rate his or her worst pain in the last 24 hours using a pain rating scale of 0-10 ("0" meaning no pain, "10" meaning the worst pain imaginable). Whole digits are recorded only.

FAAM: This self-report questionnaire is specific to the foot and ankle region in regard to ADL’s and sports activities. There are 21 items in this section. If all 21 items are completed, add the scores for each item and divide by 84 (total number of points possible) to compute the percentage score. The percentage score is rounded to the nearest whole number and recorded.

ADL Score: There are 21 items in this section. If all 21 items are completed, add the scores for each item and divide by 84 (total number of points possible) to compute the percentage score. The percentage score is rounded to the nearest whole number and recorded.

Sport Score: This is an 8 item subscale of the FAAM. If all 8 items are completed, add the scores for each item and divide by 32 (total number of points possible) to compute the percentage score. The percentage score is rounded to the nearest whole number and recorded.

Comorbidities: enter data for comorbidities on this patient.

Routine for Diagnosis: Ask the PT whether he/she routinely examines balance in an individual with this diagnosis.

Degree of Patient perceived balance problem: Ask the patient, “On a scale of 0-10, where 0 is no balance difficulties, and 10 would be balance problems so severe you could not stand, where would you place your balance abilities?”

Single Limb Stance Test: Eyes Open (EO)—patient selects stance leg

Instructions to patient: *Lift your right/left leg from the floor by bending your knee; stay standing on one leg as long as you can. Keep your arms across your chest and don’t touch*
Standing on one leg/ Eyes Closed (EC)

Instructions to patient:
Lift your right/left leg from the floor by bending your knee; stay standing on one leg as long as you can. Keep your arms across your chest and don't touch your raised leg against your other leg. Close your eyes and hold this position until I tell you to stop. (max of 30 sec)

Examiner instructions:
Subject will stand with eyes open (prior to eyes closed) on a flat surface with no external support. Timing will begin when one foot is raised off the floor. Allow the patient two attempts and record the best time. Record number of seconds the person can hold this posture up to a maximum of 30 seconds. Stop timing when the subject moves their hands from chest, touches foot against stance leg, moves stance foot around, or touches foot/toe down. Subject is allowed to use preferred stance leg for test. Allow two attempts and record the best trial for each condition.

Strategy: record your assessment of ankle sway strategy/ hip strategy

Tandem Stance -EO (Sharpened Romberg)

Instructions to patient:
Place one foot directly in front of the other so that the toes of one foot are touching the heel of the other. Place your arms across your chest. Stand like this until I tell you to stop (max 30 sec).

Tandem Stance -EC

Instructions to patient:
Place one foot directly in front of the other so that the toes of one foot are touching the heel of the other. Place your arms across your chest and close your eyes. Stand like this until I tell you to stop (max 30 sec).

Examiner instructions:
Do the tests in order (EO then EC). Record the time the patient was able to stand in each condition up to a maximum of 30 seconds and average both times. If patient is unable to assume tandem stance position, record as unable.

Forward Reach

Instructions to patient:
Stand normally. Lift your arm straight in front of you. Stretch your fingers and reach forward as far as you can. Please do not touch the ruler. Once you have reached as far forward as you can, return to a normal standing position. I will ask you to do this twice. Do not lift your heels from the floor.

Examiner instructions:
Place a ruler at shoulder height at the end of the fingertips when the arm is out at 90 degrees. The fingers should not make contact with the ruler. The patient may not lift heels, rotate trunk, or protract scapula excessively. The patient must keep their arm parallel to ruler and may use the less involved arm. The recorded measure is the maximum horizontal distance reached by the patient. Record best reach and strategy used (ankle or hip).

Walking VOR Test- with horizontal head turns

Instructions to patient:
Begin walking at your normal speed, when I say “right”, turn your head and look to the right; when I say “left” turn your head and look to the left. Try to keep yourself walking in a straight line.

Examiner instructions:
Allow the patient to reach their normal gait speed, and call the commands, “right, left” every 3-5 steps. Record the most appropriate score:
(3) Normal, performs head turns smoothly with no change in gait.
(2) Mild, performs head turns smoothly with slight change in gait speed, minor disruption to smooth gait path, veering right or left.
(1) Moderate, performs head turns, but slows down OR staggers, but recovers and continues to walk.
(0) Severe impairment, performs task with severe disruption of gait, OR staggers outside a 15” path, loses balance, stops, reaches for assistance and needs assistance to prevent a fall.
To grade: mark the lowest category that applies.

Balance Problem Identified? Mark Yes or No, by your or PT’s assessment.
Balance Problem Treated? Make Yes or No, whether you/PT believe treatment was oriented to improving balance.