ANKLE QUESTIONNAIRE
Advanced Sportsmedicine Center

1. FULL NAME: ____ **AGE:** _____ **TODAY'S DATE:** ____/____/____

2. Which ANKLE bothers you? RIGHT☐ LEFT☐ BOTH☐

3. When was the **first time** you ever had ankle symptoms?________________________________

4. When did your **present** ankle problem begin and how did it occur? ________________________
____
____
____

5. How far or how long can you walk without stopping because of symptoms? _____Hours ______Miles Unlimited

6. How long can you stand before symptoms begin? ______Hours _____Miles Unlimited

7. Have you had prior **right** ankle injuries? YES☐ NO☐ If so, when & what? ______________________

8. Have you had prior **left** ankle injuries? YES☐ NO☐ If so, when & what? ______________________

9. What part of your ankle hurts? TOP☐ BOTTOM☐ OUTSIDER☐ INNER SIDE☐ FOREFOOT☐ HEEL☐
NONE☐

10. Do you have pain while trying to sleep at night? YES☐ NO☐

11. What causes ankle pain?
WALKING☐ CLOSED TOE SHOES☐ UNEVEN SURFACES☐ HARD SURFACES☐ MOTION☐
WALKING BAREFOOT☐ SHOES WITH HEELS☐ STAIRS☐ NONE ☐ OTHER________________________

12. When is your pain the worst? MORNING☐ WITH WEIGHT BEARING DURING ACTIVITY☐ AFTER ACTIVITY ☐
EVENING☐ WITH MOTION☐ NONE ☐ OTHER____

13. My ankle pain is now getting: WORSE ☐ BETTER ☐ STAYING THE SAME☐ NONE☐

14. My ankle: POPS☐ LOCKS☐ SWELLS☐ GIVES OUT☐ HAS NONE OF THESE☐

15. My legs/feet have: LOSS OF SENSATION☐ TINGLING☐ NONE OF THESE☐

16. Are activities of daily living limited? YES☐ NO☐
If so, please list activities UNABLE to perform: ____

17. Have you had ankle X-rays? YES☐ NO☐ If so, when & where? ________________________________

18. Have you had an ankle MRI? YES☐ NO☐ If so, when & where? ________________________________

19. Has a doctor evaluated your ankle? YES☐ NO☐ If so, whom? ________________________________

20. Check any ankle treatments you have tried before today:
ICE☐ HEAT☐ REST☐ CRUTCHES/CANE/WALKER☐ BRACE/SPLINT☐ ACE WRAP☐
HOME REHAB/EXERCISES☐ INJECTIONS☐ PHYSICAL THERAPY☐ GLUCOSAMINE☐
CHONDROITIN☐ MSM☐ HERBAL REMEDIES☐ NONE☐
MEDICATIONS☐ (Please list)____

WHICH TREATMENTS HAVE HELPED? NONE☐ (Please list)________________________________