



Date of Completion:

PRIVATE & CONFIDENTIAL

PODIATRY PRE-ASSESSMENT FORM

Before attending your podiatry appointment, please fill in the details on this form, in **black ink**, so that the most is gained from your initial assessment. Please print and bring the form to your next appointment. The podiatrist will take more information during your appointment.

Patient Name: _____ **Date of Birth:** _____

Address: _____

Postcode: _____

Phone Number: _____ **Email:** _____

Next of Kin: _____ **Contact Number:** _____

Name of person completing form (If you are not the patient): _____

Relationship to patient (eg. Parent/Spouse/Guardian): _____

GP Practice Details:

Surgery Name: _____

Consultant Name: _____

Surgery Address: _____

Phone Number: _____

PLEASE FILL OUT THE FIELDS BELOW, (PLEASE MARK ALL NON APPLICABLE INFO/QUESTIONS AS N/A)

What would you like to gain from your podiatry appointment?

e.g. General foot care/maintenance, less pain, walk further, keep working, keep in sport, understand my condition

What do you believe is the cause of your concern?

Participation and Activity

Please tick if your pain and/or your general condition that is causing challenges with the following:

☐ Standing ☐ Walking ☐ Climbing Stairs ☐ Running

☐ Working ☐ Caring Duties ☐ Recreational Activity/Sport ☐ Getting Out ☐ Well-Being

Pain Levels

(1 = very low pain levels...10 = very high pain levels)

Rate your pain on a bad day? No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Rate your pain on a good day? No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐



Medical History	Yes	No	Don't Know
Have you got any diagnosed illnesses, genetic or ongoing medical problems? (e.g. Crohns, Ulcerative Colitis, Psoriasis, Diabetes, Charcot Marie Tooth)			
Have you a family history of foot problems or medical problems affecting the feet?			
Have you injured, fractured, sprained or had surgery to a part of your leg or foot?			
Have you got any allergies or sensitivities (including latex, local anaesthetic, steroids)?			
Do you smoke or vape?			
Height: Weight: Shoe Size (UK):			
Medical History-Please add any information here you think we should know:			

Are you/have you been experiencing any of the following?	Yes	No	Don't Know
Pain at night that affects your sleep.			
Recent weight loss and/or generally unwell.			
Joint pain or joint stiffness for <i>over 1 hour</i> on a morning.			
Swelling, redness or tenderness in your joints (e.g. knees, ankles, hands, wrists)			
Unusual bruising, scarring or marks of the skin or a history of wounds or ulceration			
Eye or mouth problems (i.e. dry eyes, eye pain, dry mouth)			

Information about the concern you have or have been referred to the Podiatrist for:	
Has your problem caused you pain?	
Where is your pain or, what is your concern?	
When your pain or concern originally started, how did it come on?	☐ Suddenly ☐ After an infection ☐ After Injury ☐ Gradually ☐ After Surgery ☐ After Foreign Travel
Over the last month, has your concern...	☐ Improved ☐ Worsened ☐ Stayed the same
How long have you had your concern?	
How frequently does it occur? (e.g. daily, mornings, twice a month)	
How would you describe the pain or concern? (e.g. aching, sharp, impairing)	
Information about what helps and worsens your concern:	
Does the pain or concern come on with activity?	☐ No ☐ Yes After how long:
Does the pain or concern stop at rest?	☐ No ☐ Yes After how long:
What makes the pain or concern better?	
What makes the pain or concern worse?	
What have you tried and did it help?	



Footwear

What footwear do you wear?

Have you changed your footwear to help your problem? ☐ Yes ☐ No

Do you wear specialist footwear for work? ☐ Yes ☐ No

Communication

Do you consent for Podiatry to share your care record (including test results and other information) with other services/Practices that are providing care for you?

☐ Yes ☐ No

Do you have any communication requirements or needs? ☐ Yes ☐ No

If yes please specify: _____

Do you have any special needs or requests? ☐ Yes ☐ No

If yes please specify: _____

Patient Signature: _____ Date: _____

And/or (If applicable)

Parent/Guardian Signature: _____ Date: _____