Francis J. Clark, DPM
Clay B Shumway, DPM

Patient Evaluation for todays visit

Name:______________________________Date:__________________
Height:______________ Weight:______________ Shoe Size: __________
Occupation:____Appro ximately how many hours are you on your feet per day? ____________

Are you diabetic? *Yes or No* *If yes: Type I or Type II* *Controlled or Uncontrolled*

- *Insulin Dependent*
- *Oral Medication*

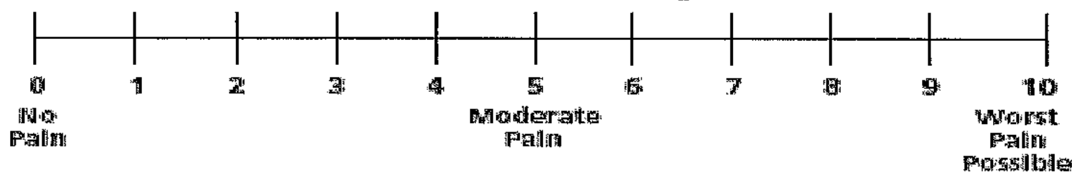
What would you like to discuss with the doctor today?

____

____

Pain Impression

It is helpful to have a description of your pain. Please circle a number that represents your pain at its average, with "1" being the lowest and "10" the highest.



Is your pain worse in the:

- Morning
- Evening
- Other ____________________________________

Sensation Impression

Please indicate what type of pain or sensation you are experiencing:

- Pins and Needles
- Numbness
- Sharp Pain
- Dull Ache
- Throbbing

Location of Sensation:

Please circle the affected areas: