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DATE: _____

PATIENT NAME: _____

NAME OF PERSON IF INFORMATION WAS NOT COMPLETED BY PATIENT: _____

OCCUAPTION/JOB DESCRIPTION: _____

PART TIME: _____ FULL TIME: _____

LENGTH OF TIME PERFORMING OCCUPATION: _____

NUMBERS OF HOURS: SEDENTARY _____ STANDING _____ WALKING _____

ANY LIFTING OF HEAVY OBJECTS: _____ DESCRIBE WEIGHT AND FREQUENCY _____

ANY SQUATTING: _____ DESCRIBE: _____

ANY CLIMBING: _____ DESCRIBE: _____

DOES YOUR JOB REQUIRE PHYSICAL TRAINING/EXERCISING: _____
 DO YOU EXERCISE REGULARLY: _____ IF YES, PLEASE ANSWER THE FOLLOWING:

DESCRIBE IN FULL DETAIL OF EXERCISE PROGRAM: DAILY _____ WEEKLY _____

RUNNING/MILES _____ ON ASPHALT/ CEMENT/TRACK-INDOOR -OUTDOOR _____

WHAT EXERCISE EQUIPMENT DO YOU USE (TREAD MILL/STAIR MASTER/WEIGHTS): _____

WHAT TYPE OF SHOES DO YOU WEAR FOR EXERCISING? _____

DATE OF INJURY: _____

PLACE OF INJURY: _____

TYPE OF SHOES WORN DURING INJURY: _____

DOES YOUR JOB REQUIRE CERTAIN TYPES OF SHOES FOR THE JOB: _____

IF YES DESCRIBE SHOES: _____

HOW DID INJURY OCCUR: _____

DID YOU REPORT INJURY: _____

TO WHOM: _____

DATE YOU REPORTED INJURY: _____

DID YOU CONTINUE TO WORK: _____

**IF TREATED BY OCCUPATIONAL MEDICAL STAFF ON THE JOB SITE, NAME OF PERSON/
 DESCRIBE TREATMENT RENDERED: _____

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PATIENT NAME: _____

DESCRIBE IN DETAIL THE FOLLOWING MEDICAL TREATMENT YOU HAVE RECEIVED.

DATE YOU FIRST RECEIVED MEDICAL TREATMENT: _____

DOCTOR NAME AND ADDRESS _____

(PRVT/WC)

WERE X-RAYS TAKEN: _____ OF WHAT AREA: _____ (NWB/WB/FX - +)

ANY FRACTURE: _____ (RW XRAY/MED)

DIAGNOSIS: _____

TREATMENT: _____

ANY MEDICATION PRESCRIBED: _____

(ANTI/PXM)

ANY RECOMMENDATIONS TO: ICE _____ (x) ELEVATE _____ (x)

OTHER HOME CARE INSTRUCTIONS: _____

WORK STATUS:

_____ I HAVE HAD NO TIME OFF; CONTINUED TO WORK REGULAR DUTY WITH OUT WORK RESTRICTIONS.

_____ I HAVE NOT RETURNED TO WORK SINCE INJURY DATE.

_____ I WAS ABLE TO RETURN TO WORK WITH THE FOLLWING MODIFICATION.

DATE RETURNED TO WORK: _____

LIGHT DUTY: _____

MODIFIED DUTY: _____

SEDENTARY: _____

WORK RESTRICTION: _____

DATE RELEASED BACK TO WORK WITH OUT WORK RESTRICTIONS: _____

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PATIENT NAME: _____

FOLLOW-UP TREATMENT RENDERED/GIVE DATES AND TYPE OF TREATMENT: _____

ANY IMPROVEMENT, SINCE INITIAL ONSET OF INJURY?: GRADE YOUR IMPROVEMENT USE SCALE OF 1 TO 10, 0= NO IMPROVEMENT, 5=50% BETTER, 10=100% IMPROVED

ANY IMPROVEMENTS: _____

ANY PHYSICAL THERAPY WITH DATES OF TREATMENT: _____

ANY IMPROVEMENT WITH PHYSICAL THERAPY: _____

HAVE YOU SEEN ANY OTHER DOCTORS/SPECIALIST NAME/ADDRESS, GIVE DATES AND TREATMENT: _____

_____ (RW XRAY/MED/MRI/BS)

ANY IMPROVEMENTS: _____

ANY CHANGE OF WORK STATUS, BY ABOVE DOCTORS, GIVE DATES:

_____ CONTINUED TO WORK, REGULAR DUTY NO WORK RESTRICTIONS.

_____ I HAVE NOT RETURNED TO WORK SINCE INJURY DATE.

_____ I WAS ABLE TO RETURN TO WORK WITH THE FOLLOWING:

DATE RETURNED TO WORK: _____

LIGHT DUTY: _____

MODIFIED DUTY: _____

SEDENTARY: _____

WORK RESTRICTIONS: _____

DATE RELEASED BACK WORK WITH OUT WORK RESTRICTIONS: _____

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PATIENT NAME: _____

WHAT ARE YOUR PRESENT COMPLAINTS,(LIST LIMATATIONS IN ACTIVITES): _____

(PX/NWB/WB)

(PX SHOES)

WORK STATUS AT THIS TIME: _____

HAVE YOU RE-INJURED AREA: _____

COMFORTABLE WITH SHOES: _____ (PXDRS/ATH/BTS)

WHAT KIND OF RECREATIONAL ACTIVITIES WERE YOU INVOLVED IN PRIOR TO INJURY:

WERE YOU ABLE TO CONTINUE WITH RECRATIONAL AND OCCUPATIONAL DUTIES,
DESCRIBE ANY CHANGES: _____

DID YOU HAVE ANY FOOT/ANKLE PROBLEM PRIOR TO INJURY: _____

HAVE YOU HAD ANY PREVIOUS INJURIES OR SURGERIES TO YOUR FEET/ANKLES: _____

LIST ALL PREVIOUS OCCUPATIONS IN CHRONOLOGICAL ORDER: _____

(REVIEW _____ / _____)
