



**BURBANK
PODIATRY
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A PROFESSIONAL CORPORATION
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DATE: _____

PATIENT NAME: _____

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

OCCUPATION/JOB DESCRIPTION: _____

PART TIME: _____ FULL TIME: _____

LENGTH OF TIME PERFORMING OCCUPATION: _____

NUMBER OF HOURS: SEDENTARY _____ STANDING _____ WALKING _____

ANY LIFTING OF HEAVY OBJECTS: _____ DESCRIBE WEIGHT AND FREQUENCY

ANY SQUATING: _____ 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: _____

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PATIENT NAME: _____

TYPE OF SHOES WORN DURING INJURY: _____

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

IF YES, DESCRIBE THE SHOES: _____

HOW DID THE INJURY OCCUR: _____

DID YOU REPORT THE INJURY: _____

TO WHOM: _____

DATE YOU REPORTED THE INJURY: _____

DID YOU CONTINUE TO WORK: _____

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

DESCRIBE IN DETAIL THE FOLLOWING MEDICAL TREATMENT YOU HAVE RECEIVED.

DATE YOU FIRST RECEIVED MEDICAL TREATMENT: _____

DOCTOR'S 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: _____

PATIENT NAME: _____

WORK STATUS:

___ I HAVE HAD NO TIME OFF; CONTINUED 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 FOLLOWING MODIFICATION.

DATE RETURNED TO WORK: _____

LIGHT DUTY: _____

MODIFIED DUTY: _____

SEDENTARY: _____

WORK RESTRICTIONS: _____

DATE RELEASED BACK TO WORK WITH OUT WORK RESTRICTIONS: _____

FOLLOW-UP TREATMENT RENDERED/GIVE DATES AND TYPES 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/SECIALIST NAME/ ADDRESS, GIVE DATES AND TREATMENT:

_____ (PRVT/WC)

_____ (PRVT/WC)

_____ (PRVT/WC)

_____ (RW XRAY/MED/MRI/BS)

ANY IMPROVEMENTS: _____

PATIENT NAME: _____

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

_____ CONTINUE 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 TO WORK WITH OUT WORK RESTRICTIONS: _____

WHAT ARE YOUR PRESENT COMPLAINTS, (LIST LIMITATIONS IN ACTIVIES): _____

_____ (PX/NWBWB)

_____ (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: _____

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PATIENT NAME: _____

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 _____/_____)
