Medico-Legal Evaluations, P.A.
Phone 732-972-4771 · Fax 732-972-0022 · info@mlenj.com · **mlenj.com**

Lower Extremity (Leg) Questionnaire

Fill out only the form(s) for the body area(s) that were injured. Type into this form on a computer or phone, save it and email it to **info@mlenj.com** before your appointment, or print it and bring it. Please also bring any X-ray, MRI or CT films or discs.

Full name | **Date of birth** | **Today's date**

Your injury

When did the injury happen?

Which part was injured? (check all that apply; if both sides, check both rows)

	Hip	Thigh	Knee	Lower leg	Ankle	Foot	Toes
Left	☐	☐	☐	☐	☐	☐	☐
Right	☐	☐	☐	☐	☐	☐	☐

How did the injury happen?

Before and after this injury

Before this injury, did you have any of these? (check all that apply)

☐ A leg or foot injury ☐ Leg or foot pain or problems ☐ Leg or foot treatment ☐ None of these

If you checked any, when and what happened (for example, another accident)?

Any other accidents or injuries since this injury? ☐ Yes ☐ No If yes, what happened?

Treatment and work

Which treatments have you had for this injury? (check all that apply)

☐ Surgery ☐ Injections ☐ Physical therapy ☐ Cast, splint or brace Other:

Work status: (check one)

☐ Full duty ☐ Light or restricted duty ☐ Not working because of this injury ☐ Retired ☐ Not working, other reason

Your job (or last job):

Pain

Do you have pain right now? ☐ Yes ☐ No

Pain right now

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Pain at its worst in the last week

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 = No pain 10 = Worst pain imaginable

Where is the pain now? (check all that apply)

	Hip	Thigh	Knee	Lower leg	Ankle	Foot	Toes
Left	☐	☐	☐	☐	☐	☐	☐
Right	☐	☐	☐	☐	☐	☐	☐

What is the pain like? (check all that apply)

☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Stinging

Other:

How often do you have pain? ☐ Sometimes ☐ Most of the time ☐ All the time

Do you have numbness, tingling or other unusual feelings in your legs or feet? ☐ Yes ☐ No

If yes, which side? ☐ Left ☐ Right ☐ Both Describe:

Pain medications you take:

Activities

Which of these activities are harder for you **because of the injury or injuries described on this form?** For each activity, **check only one box**. Leave the row blank if the injury does not affect that activity.

Activity	I can't do it anymore	I can do it, but less than before	I can do it normally, but feel pain
Standing, walking and stairs			
Standing	◯	◯	◯
Sitting	◯	◯	◯
Walking	◯	◯	◯
Going up or down stairs	◯	◯	◯
Climbing ladders	◯	◯	◯
Kneeling or squatting	◯	◯	◯
Getting in and out of a car	◯	◯	◯
Lifting and carrying			
Lifting	◯	◯	◯
Carrying objects	◯	◯	◯
Household tasks			
Doing laundry	◯	◯	◯
Mowing the lawn or gardening	◯	◯	◯
Exercise and recreation			
Walking for exercise	◯	◯	◯
Jogging or running	◯	◯	◯
Riding a bicycle	◯	◯	◯
Playing sports	◯	◯	◯
Dancing	◯	◯	◯
Daily activities			
Driving	◯	◯	◯
Putting on socks and shoes	◯	◯	◯
Sleeping	◯	◯	◯

Any other activities that are harder because of this injury: