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FOOT PAIN INTAKE FORM

Please Mark Your Problem Areas on the Image Below (on each foot, R & L)
as if you were standing on this page with these being your feet:

LEFT

RIGHT

Patient Name: _____

Date: _____

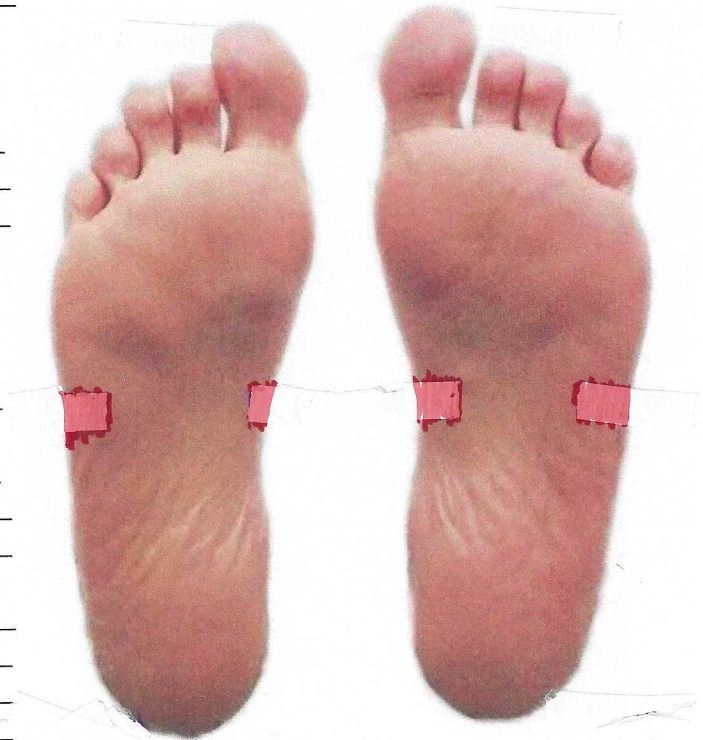
Any Previous Diagnoses? _____

Any Previous Treatment? _____

If so, Name of Health
Professional: _____

Type of Treatment: _____

Additional Remarks: _____



Doctor's Notes:

