



Name: _____ DOB: _____
 Email: _____ SSN: _____
 Sex: M F Marital Status: Single Married Widowed Divorced

Demographics

Address: _____ City: _____ State: _____ Zip: _____
 Home#: _____ Cell#: _____ Other#: _____
Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined to Specify
Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Islander White Declined to Specify
 Primary Care Doctor: _____ Date Last Seen: _____
 Other Medical Provider(s): _____ Date Last Seen: _____
 Phone#(s): _____ Address(es): _____

Hippa (Privacy Act)

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No
 Can we call the phone number on file? Yes No Can we leave voice mail on machine? Yes No
 Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No
 Next of kin: _____ Relationship: _____ POA: Yes No
 Emergency Contact: _____ Phone number: _____ Relationship: _____
 Who can we leave messages with? Wife Husband Daughter Son Other: _____
 Name(s): _____

Insurance Information

Primary Insurance: _____ Policy ID: _____ Group ID: _____
 Are you the subscriber? Yes No Subscriber Name: _____ Employer: _____
 Relationship to subscriber: Spouse Child Self other Sex: Male Female DOB: ___/___/___
 Phone #: _____ Address: _____
Secondary Insurance: _____ Policy ID: _____ Group ID: _____
 Are you the subscriber? Yes No Subscriber Name: _____ Employer: _____
 Relationship to subscriber: Spouse Child Self other Sex: Male Female DOB: ___/___/___
 Phone #: _____ Address: _____

How did you find out about our practice? Internet Telephone book Physician Friend/Family Member
Website Letter Other(specify): _____ Name of person who referred you? _____

Please read and sign

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient/responsible party signature: _____ Date: _____



Name: _____ DOB: _____

History & Physical

What is the reason for your visit today? _____

Please indicate Right Left or Both and location Ankle(s) Foot(feet) Toe(s) Toenail(s) OtherWas this due to an injury Yes No Date of Injury __/__/____ Where? Auto accident Home Other WorkHow long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is burning constant dull sharp shooting throbbing tingling other: _____

- | | | | | |
|---------------------------------------|---|--|--|---|
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Circulation | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA |
| | | | | <input type="checkbox"/> Stroke |

Other (specify): _____

Are you pregnant? Yes or No Are you nursing? Yes or No**Surgical History**None Angioplasty Appendectomy By-pass Cataracts C-Section Cholecystectomy(gallbladder)Other Surgeries (specify): _____Have you ever had any surgical procedures on foot/ankle? Yes/No (specify): _____Do you have metal or medical devices in your body? Yes/No (specify): _____Any complications with anesthesia? Yes/No (specify): _____**Social History**Are you a current smoker? Yes/No/Never If yes, how many packs per day _____ or cigarettes a day _____?

If a current/former smoker what year did you start: _____ if former what year did you quit: _____

Do you drink alcohol? Yes, everyday Yes, occasionally/socially Yes, rarely NoDo you smoke marijuana? Yes/No How often? _____Substance abuse problem? Yes/No (specify): _____What is your occupation? _____ Does it involve mostly standing or sitting?Do you exercise regularly? No/Yes, I do the following regular exercise: _____**What is your shoe size?** _____ How tall are you? _____' _____" How much do you weigh? _____



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Family History

Please list biological family health history including only parent(s), sibling(s) or child(ren):

- Alzheimer's, Arthritis, Bleeding Disorder, Blood Clot, Cancer, Other, Cataracts, Circulation Disorder, Other Circulation, Dementia, Depression, Diabetes Type I or II, Emphysema, Heart Disease, High Blood Pressure, Neurological, Strokes

Medications

Current Medications

- Not currently taking medications, I take the following medications, I provided a list to the receptionist

Name: _____

Allergies

- No known allergies, No known drug allergies, I provided a list to the receptionist

Name: _____ Reaction: _____

Review of Systems

- Cardiovascular: NONE, Cold hands/feet, Congestive heart failure, Leg pain w/rest, Leg pain w/walking, Leg swelling, Pacemaker, Palpations, Valve problems, Varicose veins, Vascular disease
Gastrointestinal: NONE, Abdominal pain, Blood in stool, Constipation, Decrease appetite, Diarrhea, Heart burn, Increase appetite, Trouble swallowing, Ulcers, Vomiting
Genitourinary: NONE, Blood in urine, Decrease frequency, Excessive urination, Hesitancy, Incontinence, Increased urgency, Kidney disease, Kidney stones
Hematologic: NONE, Anemia, Blood thinners, Clotting disorders, Lower leg ulcers, Sickle cell disease
Integumentary: NONE, Athletes foot, Dry, scaly skin, Eczema, Itchiness, Nail abnormalities, Keloids
Musculoskeletal: NONE, Arthritis, Back pain, Gout, Hip pain, Joint instability, Joint pain, Joint swelling, Knee pain, Muscle pain, Muscle weakness, Neck pain, Sciatica
Neurological: NONE, Dizziness, Headaches, Numbness, Paralysis, Seizures, Tingling, Weakness
Respiratory: NONE, Chest pain, COPD, Coughing, Emphysema, Shortness of breath, Snoring