

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____
 Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Work #: _____
 Pharmacy: _____ Phone: _____
 Primary Care Physician: _____ Phone: _____ Date Last Seen: _____
 Address: _____
 Employer: _____ Phone: _____
 Address: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? Yes No

Policy ID: _____

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____

What is the reason for your visit today? _____

How 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: _____

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. _____ (Patient Signature)

History and Physical

Name: _____ DOB: _____ Chart Number: _____

- Medical History:**
- | | | | | | |
|---|--|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues | |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes (type 1, type 2) | | |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Skin disorders (specify) _____ | | | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> other (specify) _____ | | | | |
- Are you pregnant?** Yes No **Are you nursing?** Yes No

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? Yes, I do the following regular exercise: _____

No, I do not exercise regularly

Family History

 Is there any family history (blood relative) of: (Please indicate family member)

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

Review of Systems

 (Please check the box if you currently have any of these symptoms)

- | | | | | | |
|-------------------------|--|--|--|--|---|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> constipation | <input type="checkbox"/> increase appetite | <input type="checkbox"/> decrease appetite |
| Integumentary | <input type="checkbox"/> athletes foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorders |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | |

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