NORTHWEST FOOT AND ANKLE INSTITUTE PLLC
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BELLINGHAM WA 98226
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NEW PATIENT INTAKE FORM

Name: _____ **DOB:** _____

Address: _____ **Gender:** _____

City/State/Zip: _____ **Marital Status:** _____

Home Phone: _____

Cell Phone: _____

Email: _____

- **Permission to leave Voice Message:** YES ___ NO ___
- **Preference for APPOINTMENT notifications:**

(check ONE) Phone ☐ Text ☐ E-mail ☐

Any religious practice(s) that would affect your medical care? YES/NO If yes, pleases explain: _____

Employer: _____ **Occupation:** _____

Spouse/Parent: _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Care Provider: _____ Phone: _____

Referring Provider: _____ Phone: _____

How did you hear about us? Online*☐ *Friend*☐ *Referring Doctor*☐ *Insurance Company*☐ *Other _____

Primary Insurance: _____ Phone: _____

Subscriber: Self ___ Other Subscriber: _____ DOB (if other): _____

Member ID: _____ Group#: _____

Secondary Insurance: _____ Phone: _____

Subscriber: Self ___ Other Subscriber: _____ DOB (if other): _____

Member ID: _____ Group#: _____

If someone other than the PATIENT is responsible for payment, please complete the following:

Responsible Party/ Custodial Parent: _____

Relationship to Patient: _____ Phone: (_____) _____

Address: _____ Employer: _____

If Job related, please provide:

Claim Number: _____ Claim Manager: _____ Attending Physician: _____

REASON FOR THIS VISIT: _____

Date of Injury or Onset of Problem: _____ **Pain Scale:** No Pain / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 - Worst

Personal Medical History: Height:_____ Weight: _____ Shoe Size:_____

**Please check ALL that apply:* Anemia:___ Arthritis: ____ Asthma: ____ Back Pain: ____ Blood Clots: ____ Cancer:____

Diabetes: ____ Gout:____ Heart Disease: ____ High Blood Pressure: ____ High Cholesterol: ____ Kidney Disease: ____

Liver Disease: ____ Lung Disease: ____ Neuropathy:____ Pacemaker: ____ Stroke:_____ Vascular Disease: ____

List anything else you would like us to know about your medical history: _____

_____

Previous Surgeries/Hospitalization: _____

Please list ALL Current Medications *(including supplements/over-the-counter meds)*:

_____

_____

Preferred Pharmacy: _____Phone: _____

Allergies:_____

Social History *(please circle Y/N)*:

Current Smoker? YES/NO **If YES*, How Much?___ **Former Smoker?** YES/NO **If YES*, How Much?___Years of Use:___

Do you drink alcohol? YES / NO If YES, quantity Per Week? _____ Recreational Drug Use? YES/NO_____

Family Medical History:

Mother:_____

Father:_____

Current Symptom/Concerns *(please circle)*:

General: fever / chills / loss of appetite / fatigue / weakness / weight loss / weight gain

Eye: blurring / redness / pain / itching

Ears/Nose/Throat: ear pain / hearing loss / congestion / sore throat / mouth lesions

Cardiovascular/Respiratory: chest pain / palpitation / coughing / wheezing / shortness of breath

Gastrointestinal: nausea / vomiting / diarrhea / constipation / pain

Genital/ Urinary: increased frequency / pain / incontinence / swelling

Musculoskeletal: low back pain / joint pain or swelling / muscle cramps / limited motion

Skin: rash / ulcers / redness / flaking / bruising / changes in hair or nails

Neurology: weakness / numbness / tingling / frequent falling / balance problems

Psychiatric: depression / anxiety / insomnia / stress / loss of interest

Endocrine: heat intolerance / cold intolerance / increased thirst / increased sweating

Allergies: sneezing / runny nose / hives / itching

Patient Signature: _____**Date:** _____