



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

Employer: _____ Occupation: _____

Spouse/Parent: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: _____ City: _____

Are there any religious practice(s) that may affect your medical care? YES/NO (Circle one) If yes, please explain: _____

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: (_____) _____

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 Lung Disease Neuropathy Pacemaker Stroke
 Vascular Disease

Any other pertinent medical history? _____

Previous Surgeries/Hospitalizations: _____

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

Please access my medication history electronically No current medications No drug allergies

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 / 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:** _____