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:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Diabetes (type 1, type 2)
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Skin disorders *(specify)* _____
☐ Arthritis *(specify)* _____ ☐ 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)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

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

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

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Practice: **Chart Number:**

Name: _____ **Date of birth:** _____

Race: _____ ☐I prefer not to answer ☐I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐I prefer not to answer ☐I do not know

Preferred Language: _____ ☐I prefer not to answer

Privacy Information Preferences

Were you offered a copy of the HIPAA Privacy Practice Notice? ☐Yes ☐ No

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 voicemail on answering machine? ☐Yes ☐No

Will you allow internet based delivery reminders like email? ☐Yes ☐No

Who can we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son

☐ Other: _____

Smoking Status

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Never Smoker

☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____

Weight: _____

☐I prefer not to answer ☐I do not know

Current Medications ☐None

☐ I take these prescription or over the counter medications:

Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____

Use the back of this form if more room is needed

Allergy	**Reaction**
☐ No Known Allergies	
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine *(iodine)*	_____
☐ Aspirin	_____
☐ Tylenol™	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other *(specify)*	_____

_____

_____

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