PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: __________________ __________________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

LAST FIRST MI

HOME ADDRESS: ____________________________________ CITY /STATE: ______________________ ZIP: __________

SOCIAL SECURITY NUMBER: ____________________ EMPLOYER: ____________________ OCCUPATION: ______________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO RACE: ( ) AFRICAN ( ) EUROPEAN ( ) ASIAN

WORK PHONE #: (____) ____-_______ YES NO ETHNICITY: ( ) ASIAN ( ) BLACK ( ) LATINO

CELL PHONE #: (____) ____-_______ YES NO ( ) PACIFIC ISLANDER ( ) WHITE

E-MAIL: _______________________________ YES NO PRIMARY LANGUAGE: ______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ___________________________ RELATIONSHIP: ____________ PHONE #: (____) ____-_______

EMERGENCY CONTACT: __________________________ RELATIONSHIP: ____________ PHONE #: (____) ____-_______

PRIMARY CARE DOCTOR: ____ PHONE: ____________________________

PHARMACY: ________________________ LOCATION: _________________________ PHONE #: (____) _____-________

WHO IS RESPONSIBLE FOR PAYMENT? ____________________________ RELATIONSHIP TO PATIENT? _________________

ADDRESS: ______________________ CITY/STATE: _________________ ZIP: _______ PHONE #: (____) ____-_______

WHO REFERRED YOU TO US? ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

INSURED NAME: ________________________ DATE OF BIRTH _____________ EMPLOYER _________________________

INSURED SOCIAL SECURITY NUMBER: _______________________ CONTRACT # _______________ GROUP # ____________

SECONDARY INSURANCE COMPANY NAME: ____

INSURED NAME: ________________________ DATE OF BIRTH _____________ EMPLOYER _________________________

INSURED SOCIAL SECURITY NUMBER: _______________________ CONTRACT # _______________ GROUP # ____________

PATIENT NAME: _______________________________
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

REVIEW OF SYSTEMS

GENERAL	( ) CHANGE IN APPETITE	( ) CHILLS/FEVER	( ) FATIGUE
SKIN	( ) RASH	( ) ITCHING	( ) LESION/LUMPS/SORES
HEAD	( ) DEFORMITY	( ) HEAD INJURY	( ) HEADACHE
EYES	( ) BLURRED VISION	( ) CHANGE IN VISION	( ) CATARACTS
EARS	( ) DEAF	( ) DECREASED HEARING	( ) DIZZINESS
NOSE & SINUSES	( ) LOSS OF SMELL	( ) NOSE BLEEDS	( ) SINUS PROBLEMS
MOUTH & THROAT	( ) DRY MOUTH	( ) SORES ON TONGUE	( ) TOOTHACHE
NECK	( ) ENLARGED THYROID	( ) NECK MASS	( ) NECK PAIN
RESPIRATORY	( ) SHORTNESS OF BREATH	( ) COUGH	( ) CLUBBING OF FINGERS
CARDIOVASCULAR	( ) CHEST PAIN	( ) HIGH BLOOD PRESSURE	( ) EDEMA
GASTROINTESTINAL	( ) NAUSEA	( ) VOMITING	( ) ABDOMINAL PAIN
GENITOURINARY	( ) FREQUENCY	( ) INCONTINENCE	( ) INFECTION
MUSCULOSKELETAL	( ) LIMITATION MOTION	( ) MUSCLE CRAMPS	( ) STIFFNESS
P VASCULAR	( ) CALF PAIN	( ) LEG CRAMPS	( ) REST PAIN
NEUROLOGIC	( ) NUMBNESS	( ) SEIZURES	( ) MEMORY LOSS
PSYCH	( ) ANXIETY	( ) DEPRESSION	( ) INSOMNIA
ENDOCRINE	( ) EXCESSIVE THIRST	( ) EXCESSIVE URINATION	( ) THYROID PROBLEMS
HEMATOLOGIC	( ) ANEMIA	( ) EASY BRUISING	( ) BLOOD TRANSFUSION

OTHER ___________________________________

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____________________
☐ ANESTHESIA ____________________ ☐ FOODS ____________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ____________________
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

( ) CANCER
( ) OB/GYN
( ) SKIN ( ) SCLERODERMA ( ) STEVEN JOHNSON
( ) HEAD, EYES, EARS ( ) CATARACTS ( ) MACULAR DEGENERATION ( ) RETINAL DETACHMENT ( ) BLIND ( ) DEAF
( ) RESPIRATORY DISEASE ( ) ASTHMA ( ) COPD ( ) PULMONARY EMBOLISM ( ) SLEEP APNEA
( ) CARDIAC PROBLEMS ( ) CONGESTIVE HEART FAILURE ( ) CORONARY ARTERY DS ( ) BLOOD CLOT ( ) STROKE
( ) HIGH CHOLESTEROL ( ) HYPERTENSION ( ) MITRAL VALVE PROLAPSE ( ) MURMUR
( ) GASTROINTESTINAL ( ) GASTRO-ESOPHAGEAL REFLUX ( ) HEPATITIS ( ) IBS ( ) PEPTIC ULCER
( ) URINARY ( ) RENAL FAILURE ( ) DIALYSIS
( ) MUSCULOSKELETAL ( ) BACK PAIN ( ) OSTEOARTHRITIS ( ) OSTEOPOROSIS ( ) RAYNAUD'S ( ) RSD
( ) NEURO ( ) ALZHEIMER'S ( ) MULTIPLE SCLEROSIS ( ) NEUROPATHY ( ) PARKINSON ( ) SEIZURES
( ) PSYCH ( ) ALCOHOLISM ( ) ANXIETY ( ) ATTENTION DEFICIT ( ) DEPRESSION ( ) DRUG ABUSE
( ) HEMATOLOGIC/LYMPH ( ) ANEMIA ( ) SICKLE CELL
( ) ENDOCRINE ( ) DIABETES ( ) HYPERTHYROIDISM ( ) HYPOTHYROIDISM ( ) OBESITY
( ) ALLERGY/IMMUNOLOGY ____________________
( ) INFECTIOUS DISEASE ( ) AIDS ( ) HIV ( ) OSTEOMYELITIS
( ) RHEUMATOLOGY ( ) ANKYLOSING SPONDYLITIS ( ) FIBROMYALGIA ( ) GOUT ( ) REITER'S ( ) RHEUMATOID ARTHRITIS
( ) TRAUMA ( ) MOTOR VEHICLE ACCIDENT ( ) FRACTURES / BROKEN BONES
( ) OTHER ____________________

SOCIAL HISTORY

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____________________

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE ____________

☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

MOTHER: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

Patient Name: ______________________________
Date of Birth: ____/____/_____

Father: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

Sister: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

Brother: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

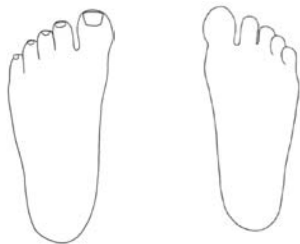
Child: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

Current Problem

What specific problem brings you to our office today? ______________________________

Where is the pain/problem located? Please mark on the pictures below.

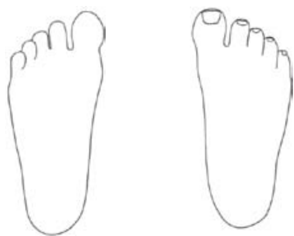
Left Foot



Top of Foot Bottom of Foot

Inside of foot Outside of Foot

Right foot



Bottom of Foot Top of Foot

Outside of Foot Inside of foot

How long ago did this problem first start? _________ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other ______________________________

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER ______________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO
IF NOT WORK RELATED, WHERE DID IT HAPPEN? ______________________________

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO: ______________________________
NAME RELATIONSHIP

( ) YES ( ) NO I AUTHORIZE PAYMENTS BE MADE DIRECTLY TO MY MEDICAL PROVIDER

( ) YES ( ) NO I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY INSURANCE

( ) YES ( ) NO I AUTHORIZE THE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES. THIS INFORMATION MAY CONTAIN INFORMATION PERTAINING TO COMMUNICABLE OR VENEREAL DISEASE.

( ) YES ( ) NO I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

PRINT NAME: ______________________SIGNATURE:______________________DATE:______________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

______________________________ ______________________________
PRINT NAME OF PATIENT, PARENT OR GUARDIAN IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

______________________________ ______________________________
SIGNATURE DATE