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 ☐fainting	☐fever ☐ palpitations	☐ chest pain/pressure ☐vascular disease	☐leg swelling ☐valve problems	☐cold hands/feet
Genitourinary	☐blood in urine ☐decreased frequency	☐hesitancy ☐excessive urination	☐incontinence ☐kidney disease	☐increased urgency ☐kidney stones	
Gastrointestinal	☐abdominal pain ☐diarrhea	☐heartburn ☐trouble swallowing	☐blood in stool ☐constipation	☐vomiting ☐increase appetite	☐ulcers ☐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 ☐tremors	☐weakness ☐paralysis	☐seizures	☐numbness	☐headaches
Musculoskeletal	☐back pain ☐sciatica	☐joint swelling ☐joint stiffness	☐muscle weakness ☐joint pain	☐muscle pain ☐joint instability	☐neck pain ☐arthritis
Respiratory	☐chest pain ☐shortness of breath	☐wheezing ☐emphysema	☐COPD	☐coughing	☐snoring

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)

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)*____________	

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)*