Patient Information Form

(Please Print)

Date: ____/_____/_____

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

Age: ____ Sex: M F

Last First MI

Home Address: _____ City/State: _____ Zip: _____

May we leave a message?

Home Phone #: (_____) _____-_____ Yes No

Work Phone #: (_____) _____-_____ Yes No

Cell Phone #: (_____) _____-_____ Yes No

E-mail: _____ Yes No

Primary Language: _____

Race:_____

Ethnicity:_____

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 #: (_____) _____-_____

Is there a family member or other person you would like for us to share your medical information?

_____ Yes Name(s)

_____

_____ No

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

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

WHO REFERRED YOU TO US?

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:

_____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME:

_____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

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

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

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

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

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

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

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

TYPES OF EXERCISE:

_____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS
☐ OTHER

_____

_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS

_____

☐ ANESTHESIA _____ ☐ FOODS

_____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER

_____

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/ EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

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

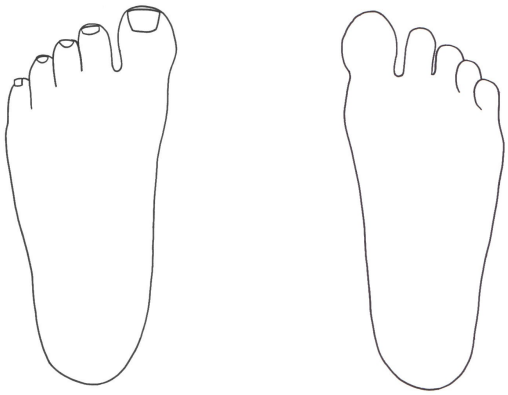
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

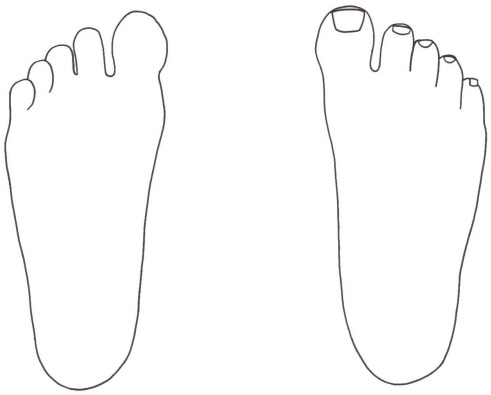
_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



RIGHT 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

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

_____

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

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

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

SIGNATURE OF DOCTOR

_____
_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

_____
SIGNATURE

_____
DATE