

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

*E-mail newsletters, reminders, statements, etc.*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary 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: \_\_\_\_\_ Employer: \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_

# 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  Cancer  Hepatitis  
 Neuropathy (specify) \_\_\_\_\_  Thyroid disease (specify) \_\_\_\_\_  Diabetes (type 1, type 2)  
 Arthritis (specify) \_\_\_\_\_  other (specify) \_\_\_\_\_  HIV  CVA  
**Are you pregnant?**  Yes  No **Are you nursing?**  Yes  No  Skin disorders  Stroke

**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?  No, I do not exercise regularly  Yes, I do the following regular exercise: \_\_\_\_\_

## Family History

 Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

## Review of Systems

 (Please check the box if you currently have any of these symptoms or check "NONE")

<b>Cardiovascular</b>	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE	
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency		
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE	
<b>Gastrointestinal</b>	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE	
<b>Integumentary</b>	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> NONE
<b>Hematologic</b>	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> NONE
<b>Neurological</b>	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches	
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE	
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis	<input type="checkbox"/> NONE
<b>Respiratory</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE	

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Date: \_\_\_\_\_