Name:______________________________________DOB:__________________SSN:_________________

Address:__________________________________________City:________________________________

State:__________ Zip:_____________ Birth Gender:___________Gender Identity:______________

Preferred Phone:__________________________cell home Alternate Phone: _____________________

Email: ________________________________________Marital Status: Single Married Widow Divorced Separated

Employer:________________________________________Job Title:_____________________________

Employer Address:_______________________________________________________________________

Work Phone:________________________________________________Is it OK for us to call you here? Yes No

How did you hear about us?_______________________________________________________________

Emergency Contact #1_____________________________________Relationship:_________________

Phone:_________________________________________Alternate Phone:_________________________

Emergency Contact #2____________________________________Relationship__________________

Phone:_________________________________________Alternate Phone:_________________________

Primary Insurance:_________________________________ID:_________________________________

If the insurance is not in your name, please provide the following information:

Subscriber Name:_______________________________Relation:_________________DOB:___________

Secondary Insurance________________________________ID____________________________________

Subscriber Name:_______________________________Relation_________________DOB____________

Race/Ethnicity

______American Indian/Alaska Native ______Latino/Hispanic ______Black/African American

______Native Hawaiian/Pacific Islander ______Asian ______White

______Decline to specify

Preferred Language: English Other_____________________________________________

Is interpretation/translation needed for visits? Please circle one. **YES** **NO**

Is this visit due to an accident or traumatic injury? Yes No

If yes, have you filed or do you plan to file a workman's comp claim? Yes No

If either is yes, we need authorization prior to you being seen in our office.

If the patient is a minor or is not their own guardian, please provide the information below:

Legal Guardian Name:____________________________________Relation:______________________

DOB:_______________SSN:_______________________________Phone:___________________________

Address (if different from above):________________________________________________________

**Signature:**_______________________________________________**Date:**____________________________

Relationship (if other than patient):______________________________________________________

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**PLEASE COMPLETE ALL PARTS OF THIS FORM. IT IS IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS.**

Name ________________________________ Age ____

Date of Birth ___________________________________

Birth Gender __________ Gender Identity ___________

Primary Doctor's Name ______________________________
(first) (last)

Date Last Seen by Primary ___________________________

Pharmacy Name & Location ___________________________

| **Past Medical History:** "X" your current/past conditions | |
|---|---|
| ○ AIDS/HIV | ○ **Healing Problems** |
| ○ Anemia | ○ Heart Disease |
| ○ **Anesthesia Problems** | ○ Hepatitis |
| ○ Anxiety/Depression | ○ High Blood Pressure |
| ○ Arthritis | ○ Kidney Disease |
| ○ Asthma | ○ Kidney Stones |
| ○ Autoimmune Disorder | ○ Leg/Foot Ulcers |
| ○ Back Pain | ○ Liver Disease |
| ○ **Bleeding Disorder** | ○ Lung Disease |
| ○ **Blood Clot/DVT** Location:__________ Year:____________ | ○ Organ Transplant: Type:______________ Year:______________ |
| ○ Cancer: Type__________ | ○ Osteoporosis |
| ○ Coronary Artery Disease | ○ Other Heart Issues |
| ○ Diabetes: T1 or T2 ○ Year Dx:________ | ○ PTSD |
| Dialysis | ○ Pacemaker |
| ○ Dyslipidemia | ○ Peripheral Vascular Disease |
| ○ Edema | ○ Pneumonia |
| ○ Ehlers Danlos Syndrome | ○ Pulmonary Embolism |
| ○ Emphysema/COPD | ○ Raynaud's Disease |
| ○ Fibromyalgia | ○ Rheumatoid Arthritis |
| ○ Foot Deformity | ○ Seizures/Epilepsy |
| ○ Gout | ○ Stroke |
| ○ Headaches | ○ Thyroid Problems |
| ○ **Malignant Hyperthermia** | ○ Varicose Veins |

| **Social History:** |
|---|
| Are you able to walk: **Yes** **No** **with Assistive Device** |
| Exercise Level: **None** **Occasional** **Moderate** **Heavy** |
| How many days per week: **1-2** **3-4** **5-7** |
| Are you currently in school: **Yes** **No** |
| Are you currently employed: **Yes** **No** **Retired** |
| Occupation: **N/A** |
| Do you or have you ever smoked tobacco: **Never** **Former Smoker** **Current Smoker** |
| What is your level of alcohol consumption: **None** **Occasional** **Moderate** **Heavy** |
| How many days per week: **1-2** **3-4** **5-7** |
| Do you use any illicit or recreational drugs: **Yes** **No** |
| What is your level of caffeine consumption: **None** **Occasional** **Moderate** **Heavy** |
| What is your relationship status: **Married** **Single** **Divorced** **Separated** **Widowed** **Other** |
| **Shoe Size:** Left _________ Right__________ |

| **Medications:** Prescribed & Over the Counter ☐ **N/A** | | |
|---|---|---|
| **Name** | **Dose** | **Frequency** |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |
| **7.** | | |

| **Allergies:** Drugs & Reactions ☐ **None** |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |

| **Vaccinations:** | **Dates** |
|---|---|
| **Covid-19: Y/N** | |
| **Influenza: Y/N** | |
| **Pneumonia: Y/N** | |

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| **Surgeries/Hospitalizations (Feet & All Others)** | **Type/Date** |
|---|---|
| Ankle Surgery **Yes No Lt/Rt** | |
| Foot Surgery **Yes No Lt/Rt** | |
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |

**Family History:**

| | Mom | Dad | Sister | Brother | Daughter | Son |
|---|---|---|---|---|---|---|
| AIDs/HIV | | | | | | |
| Alzheimer's | | | | | | |
| Anemia | | | | | | |
| Anesthesia Problems | | | | | | |
| Arthritis | | | | | | |
| Asthma | | | | | | |
| **Bleeding Disorder** | | | | | | |
| **Blood Clots** | | | | | | |
| Cancer | | | | | | |
| Depression | | | | | | |
| Diabetes | | | | | | |
| Emphysema | | | | | | |
| Heart Disease | | | | | | |
| Heart Attack | | | | | | |
| High Blood Pressure | | | | | | |
| High Cholesterol | | | | | | |
| Kidney Disease | | | | | | |
| Neurological Disorder | | | | | | |
| Psychiatric Disorder | | | | | | |
| Raynaud's Syndrome | | | | | | |
| Seizures | | | | | | |
| Stroke | | | | | | |
| Thyroid Disease | | | | | | |
| Ulcers: Foot/Leg | | | | | | |
| Other: | | | | | | |

**Review of Systems:** Have you experienced any of these symptoms in the *last few weeks*?

**General** □fever □fatigue □chills □trouble sleeping □weakness □weight gain □weight loss

**Head/Neck** □dry eyes □irritation □vision change □eye disease/injury □wears glasses/contact lenses

**ENT** □difficulty hearing □ear pain □frequent nosebleed □nose problems □sinus problems □sore throat □snoring □bleeding gums □dry mouth □mouth ulcer □sinusitis □mouth breathing □ringing in ears □oral abnormalities

**Cardiovascular** □chest/arm pain on exertion □palpitation □shortness of breath: walking □ankle swelling □shortness of breath: laying down □light-headed on standing

**Respiratory** □cough □wheezing □shortness of breath □coughing up blood □sleep apnea

**Gastrointestinal** □abdominal pain □nausea □vomiting □constipation □black or tarry stools □frequent diarrhea □vomiting blood □dyspepsia □GERD

**Genitourinary** □urinary loss of control □difficulty urinating □increased urinary frequency □incomplete emptying

**Musculoskeletal** □muscle aches □muscle weakness □arthralgias/joint pain □back pain □swelling in extremity □neck pain □difficulty walking □cramps □osteoporosis

**Skin** □jaundice □rash □itching □dry skin □growth/lesions □non-healing areas □psoriasis □change in skin color

**Neurologic** □loss of consciousness □numbness □seizures □dizziness □frequent or severe headaches □migraines □restless legs □tremor □gait dysfunction □paralysis

**Psychiatric** □depression/anxiety □alcohol abuse □hallucinations □suicidal thoughts □mood swings □memory loss □dementia □delirium

**Hematologic/Lymphatic** □swollen glands □anemia □easy bruising □excessive bleeding □phlebitis

**Allergic/Immunologic** □runny nose □sinus pressure □itching □hives □frequent sneezing

**Other:**

**I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.**

**Signature:**

**Date:**

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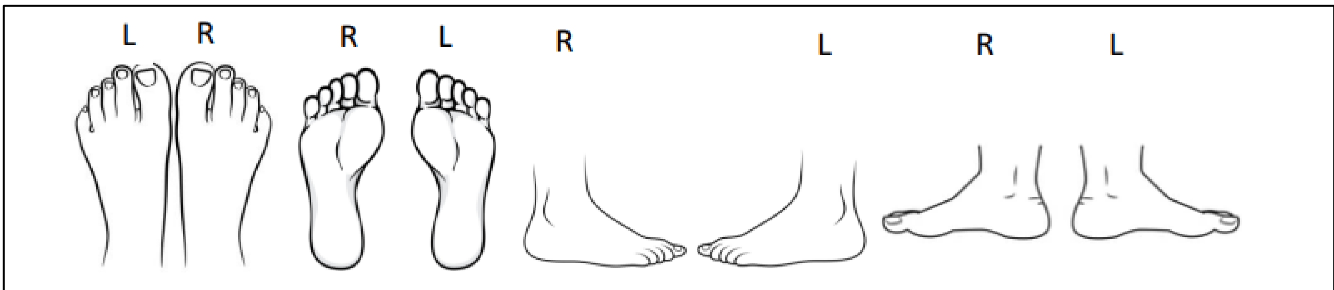
Name:_________________________________________ Date of Birth:___________________

What is bothering you today?_____________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
How many months/years has this been going on?______________________________________
How did this happen?_____________________________________________________________
_______________________________________________________________________________
Did this happen while you were at work? ◯ No ◯ Yes, Is your employer aware? ◯ No ◯ Yes

Mark the location of the problem(s) with an X




If "0" is no pain or discomfort and "10" is the worst pain or discomfort you ever had, how would you rate your pain or discomfort over the last several days? (circle number)

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Is your pain constant? ◯ No ◯ Yes
What have you done to treat it? Orthotic ______ Brace ______ Anti-inflammatory ______
Lotion/cream ______Antibiotic ______ Changed shoe _______ Ice ______Elevation______
Other_________________________________________________________________________
What makes your symptoms worse?_________________________________________________

Signature: ____________________________________________Date:________________