PATIENT INFORMATION

Patient _____ Patient SS# _____
LAST FIRST MI

Address _____ Zip _____
Home Phone _____ Work _____ Alternate/Cell _____
Sex: ____ M ____ F Age_____ Date of Birth _____ Marital Status _____
Employer _____ Occupation _____
Employer Address _____ Zip _____
Spouse's Name _____ SS # _____ Date of Birth _____
Spouse's Employer _____ Occupation_____ Phone _____
Employer Address _____ Zip _____
Guardian's Name if Patient is a Minor_____ Phone_____
Address if different from above _____ Zip _____
By whom were you referred? _____

INSURANCE INFORMATION:

Insurance Co. _____ Subscriber # _____ Group # _____
Subscriber Name _____ Date of Birth _____
Relationship to Patient _____ SS # _____
Is patient covered by additional insurance? Yes ____ No____
Secondary Insurance Co. _____ Subscriber # _____
Group # _____ Subscriber Name _____Date of Birth _____
Relationship to Patient _____ SS # _____
Who is responsible for this account? _____

MEDICAL HISTORY: Do you suffer from (now or in the past) any of the following illnesses or conditions:

AIDS/HIV	_____	Eye Problems	_____	Respiratory Disease	_____
Anemia	_____	Fainting	_____	Rheumatic Fever	_____
Angina	_____	Foot or Leg Cramps	_____	Shortness of Breath	_____
Arthritis	_____	Gout	_____	Sinus Problems	_____
Artificial Heart Valves	_____	Headaches	_____	Special Diet	_____
Or Joints	_____	Heart Disease	_____	Stroke	_____
Asthma	_____	Hemophilia	_____	Swelling in Ankles, Feet	_____
Back Problems	_____	Hepatitis or Jaundice	_____	Swollen Neck Glands	_____
Cancer	_____	High Blood Pressure	_____	Tobacco	_____
Chemical Dependency	_____	Kidney Problems	_____	Years Smoked _____ Amount _____	
Chest Pain	_____	Liver Disease	_____	Tired Feet	_____
Chronic Diarrhea	_____	Low Blood Pressure	_____	Tuberculosis	_____
Circulatory Problems	_____	Nervous Problems	_____	Ulcers	_____
Diabetes *	_____	Phlebitis	_____	Varicose Veins	_____
Ear Problems	_____	Psychiatric Care	_____	Venereal Disease	_____
Epilepsy	_____	Radiation Treatment	_____	Weight Loss, unexplained	_____

* If you have Diabetes please answer the following questions:
How long have you had Diabetes? _____ What is your usual blood sugar level by finger stick? _____
How many times a day do you check your finger stick blood sugar? _____
Please explain other condition _____
Physician's Name and Address _____
Are you under the care of a doctor? ( ) Yes ( ) No Reason_____
Height: _____ Weight: _____ Shoe Size: _____

MEDICATIONS: Include prescriptions, over-the-counter medications and vitamins

_____
_____

ALLERGIES: Adhesive/Tape ___ Anesthetics ___ Anticoagulant Therapy ___ Aspirin ___ Codeine ___
Cortisone ___ Demerol ___ Iodine ___ Local ___ Novacaine ___ Penicillin ___ Sea foods ___ Sulfa

___ Other ____

CHARACTERISTICS OF PROBLEM: Please tell us as well as you can the main problem, as well as other problems, that brings you to our office for help.

_____

_____

How long have you had your current problem? _____ Years _____ Months

PREVIOUS TREATMENT: What previous treatment have you had if any for your problem (s)?

_____

ONSET OF PROBLEM: How did your current problem start?

Injury at work _____ Injury, not at work _____ Motor vehicle accident _____ Illness, non-injury ____

Treatment caused (e.g. radiation, surgery, etc). _____ Undetermined _____

If there was a precipitating event not mentioned, what was it? _____

SEVERITY OF PROBLEM: In general, over the past month, the intensity of my pain has been:

Mild _____ Moderate _____ Moderate-Severe _____ Severe _____

TIMING OF PAIN/PROBLEM: How often do you have your pain (please check one)?

Constantly (100% of the time) _____ Intermittently (30-60% of the time) _____

Nearly constantly (60-95% of the time) _____ Occasionally (less than 30% of the time) _____

In general, during the past month, when has your pain/problem been the worst (please check one)?

Morning _____ Afternoon _____ Evening _____ Night _____ No typical pattern _____

SYMPTOM QUALITY: How would you describe your pain ? (Check all that apply and circle the dominant quality)

Burning _____ Sharp _____ Cutting _____ Throbbing _____ Electric _____ Cramping _____

Dull/aching ____ Pressure-like ____ Shooting _____ Pins and needles _____ Walking on a pebble ____

Pain on first step of the day _____ Other (describe) _____

PAIN LOCATION: Check where you have the most pain.

Ankle _____ Heel _____ Big Toe _____ Other Toes _____ Leg _____ Top of Foot _____

Bottom of Foot _____ Ball of Foot _____ Other (describe) _____

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect your pain (please check one for each item)

	DECREASE	**NO CHANGE**	**INCREASE**
STANDING			
SITTING			
WALKING			
EXERCISE			
ELEVATION			

Check all that apply:

Aggravated by: Weather _____ Shoe _____ Touch _____

Relieved by: Heat _____ Cold _____ Rest _____ Meds _____ Ace or Compressive Wrap _____

Are you NOT able to perform any of the following activities of daily living? (Check all that apply)

Going to Work _____ Performing household chores _____ Doing yard work or shopping _____

Wearing Shoes _____ Participating in recreational activities _____ Exercise _____

HOW DID YOU HEAR ABOUT US?

Phone Book _____ Web Site _____ Patient/Friend/Family _____ Other _____

CONSENT:

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. I understand that I am responsible for payment at the time services are rendered, unless other arrangements have been made.

Signature of Patient or Guardian_____

Date _____