New Patient Forms

Today's Date:

Patient Name:

Date of Birth: Social Security #:

Age: Sex: M F Weight: Height: Shoe Size:

Home Address: City, State, Zip:

May we Leave a Message?

Home Phone #: Yes No

Work Phone #: Yes No

Cell Phone#: Yes No

Email: Primary Language:

Do you have a Legal Guardian or Attorney? Yes No

If yes, Name: Relationship:

Phone #:

Emergency Contact: Relationship:

Phone #:

Primary Care Doctor: Phone #:

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

No Yes, Name(s):

Who is responsible for payment?

Address: City, State Zip:

Insurance Information

Primary Insurance Company Name:

Address: City, State Zip:

Phone #: Contract #: Group #:

Medications You Are Current Taking (Include prescriptions, over-the counter meds, and supplements):

Name: Dose: How often do you take it?

Allergies:

Medications:

Anesthesia:

Foods:

Tape Latex Iodine Shellfish No Known Allergies

Please List All Prior Surgeries:

Type of Surgery: Date: Type of Surgery: Date:

Please List All Prior Hospitalizations (aside from surgeries):

Reason For Hospitaliztion: Date:

Family History (Please Indicate Mother or Father in the Textbox):

Diabetes Type 1 or 2 Cancer Heart Disease High Blood Pressure Stroke

Coronary Artery Disease Thyroid Disease Rheumatoid Arthritis

Social History (Check All That Apply):

Marital Status: Single Married Divorced Widowed

Use of Alcohol: Never No Longer Use History of Abuse

Current Use Type: Rare Occasional Moderate Daily

Use of Tobacco: Never Quit/How Long Ago: Smoke packs a day years

Use Of Recreational Drugs: Never Quit/How Long Ago: Type:

Current Use Type: Rare Occasional Moderate Daily

Employer: Occupation:

How often are you on your feet at work?: 10% 25% 50% 75% 100%

Do others depend on your for their care?: Children/Ages Pet(s)/Kind

Elderly Or Disabled Family Member: Other:

Exercise: Never Rarely Occassional Weekly Several Times Weekly Daily

Types of Exercise:

Have you ever had any of the following....

Acid Reflux	Fibromyalgia	Neuropathy
Anemia	Gout	Open Sores
Arthritis	Heart Attack	Pneumonia
Asthma	Heart Disease/Failure	Polio
Back Pain	Hepatitis	Rheumatic Fever
Bladder Infections	HIV+/AIDS	Sickle Cell Disease
Abnormal Bleeding	High Blood Pressure	Skin Disorder
Blood Clots	Kidney Disease	Sleep Apnea
Blood Transfusion	Liver Disease	Stomach Ulcers
Bronchitis/Emphysema	Low Blood Pressure	Stroke
Cancer	Migraine Headache	Thyroid Disease
Diabetes: Type 1 or 2	Mitral Valve Prolapse	Tuberculouis

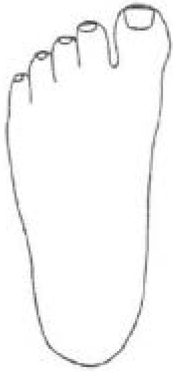
Other Conditions:

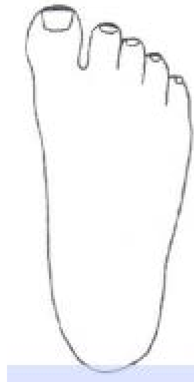
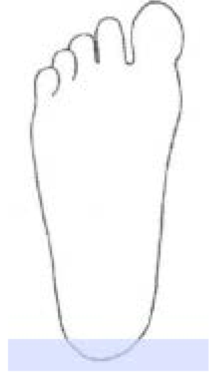
Current Problems:

What specific problems brought you to the office today? .

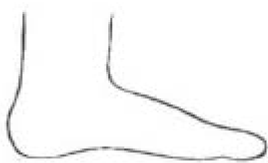
Where is the pain located? Please check on the pictures below.

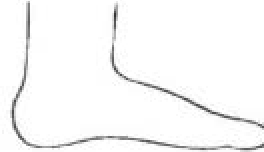
Top of foot	**LEFT**	**Bottom of foot**	**Top of foot**	**RIGHT**	**Bottom of Foot**



Inside of foot	**Outside of foot**	**Inside of foot**	**Outside of foot**





How long ago did this problem start (put a number): Days Weeks Months Years

Did your pain or problem... Begin Suddenly Gradually Developed Over Time

How would you describe your pain? No pain Sharp Dull Aching

Radiating Itching Stabbing Other

How would you rate your pain on a scale of 1-10?

Since your problem began has it... Stayed the same Become worse Improved

What makes your problem feel worse?

What makes your problem feel better?

What treatments have you had?

Has this problem affected your lifestyle and ability to work? Yes No

Was this problem caused by an injury? Yes No

If yes, was it work related? Yes No

To the best of my knowledge, I have answered the questions on this for accurately. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor and staff of changes in my medical status.

Name of patient or guardian (& relationship) Signature