Patient Information Date: ___________________________

Name: ____ Date of Birth: __________________________

Sex: ☐M ☐F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: ______________________________

Address: ___________________________________ City: ______________ State: _______ Zip Code: _______________

Phone # : _____________________________ (Home/Cell) E-Mail: ____

Employer: ______________________________________ Phone #: ____

Emergency Contact

Name: ____ Phone #: ________________________________(Home/Cell)

Relationship to patient: ___________________________

Insurance Information Are you the subscriber? ☐Yes ☐No

(Primary) Insurance: ____________________________________ Member ID #: _________________________________

Subscriber Name: ____ Date of Birth: ________________________

SS#: ______________________________ Relationship to patient: _________________________

Are you the Subscriber? ☐ Yes ☐ No

(Secondary) Insurance: _________________________________ Member ID #: __________________________________

Subscriber Name: ____ Date of Birth: ______________________________

SS#: ______________________________ Relationship to patient: _________________________

How did you find out about our practice? ☐Doctor ☐Internet ☐Family Member/Friend ☐ _______________________

What's the reason for your visit? _____________________________ Result of an accident or Work related? ☐Yes ☐No

How long has it bothered you? _______ ☐Days ☐Weeks ☐Months ☐Years

What treatment have you tried, and Have they been effective? ____

From a scale of 1-10 (1 being no pain and 10 being the worst) What's your pain level? _____/ 10

What type of pain are you feeling? ☐Burning ☐Constant ☐Dull ☐Sharp ☐Shooting ☐Throbbing ☐Tingling ☐ ________

PLEASE REAND 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 physicians and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____ **Date:** ___________________________

Name: ______________________________ Date of Birth: ____________________ Date: __________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispano/Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or Pacific Islander ☐ Declined to specify

Preferred Language: ____ ☐ Declined to specify

Pharmacy Name: ____________________________________ Phone #: ____________________________________

Address: ______________________________________ City, State, Zip:________________________________

Primary Care Physician: ____________________________________ Phone #: ______________________________

Privacy Information Preference

Do you want to be exempt from public reporting? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No

Can we send mail to the address on file? ☐ Yes ☐ No

Can we leave a voicemail? ☐ Yes ☐ No

Will you allow us to send internet based (email) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your email address: ____________________________________

Who can we leave messages with? ☐ Wife/Husband ☐ Daughter/Son ☐ Other Person: __________________________

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former Smoker ☐ Light Tobacco ☐ I decline to answer

☐ Never Smoked

Vital Signs

Blood Pressure: ________ / ________

Glucose Level: ____________________

Hemoglobin A1C: ________________

Current Medications

☐ No Known Medication

☐ I take the following medications:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Allergies

☐ No Known Allergies

☐ No Known Drug Allergies:

1. ______________________ Reaction: ______________
2. ______________________ Reaction: ______________
3. ______________________ Reaction: ______________
4. ______________________ Reaction: ______________
5. ______________________ Reaction: ______________
6. ______________________ Reaction: ______________

Last Flu Shot Date: ________________ Did you get a Pneumococcal Vaccination ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No Were you injured from the fall? ☐ Yes ☐ No

Have you completed any Advance Directives? ☐ Yes ☐ No

Please read and sign: The information on my intake form(s) 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. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPPA Privacy)*: I acknowledge that I received my HIPPA Privacy Practice Notice. *(Medical History)*: I authorize the Doctor's office to retrieve my medical history.

Patient Signature: ____ **Date:** __________________________

Name: ______________________________________ Date of Birth: ________________ Date: ________________

Medical History:
☐Alcoholism ☐Blood Disorder ☐ 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
☐HIV ☐CVA ☐Stroke ☐Cancer ☐Hepatitis ☐Neuropathy *(specify)*___________
☐Thyroid Disease *(specify)*_____________ ☐Diabetes (Type 1, Type 2) ☐Arthritis *(specify)*______________
☐Other *(specify)*______________ **Are you Pregnant?** ☐ Yes ☐ **No** **Are you Nursing?** ☐ Yes ☐ No

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 joint? ☐Yes (Where: ___________) ☐No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
¿Do you smoke? ☐Yes ☐ No If yes, how many packs a day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long? ___________
Do you drink alcohol? ☐Yes, Everyday (5-7 day/week) ☐Yes, Occasionally/Socially ☐No, Rarely
Substance Abuse? ☐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 ☐Sitting
Do you exercise regularly? ☐No, I do not exercise regularly
☐Yes, I do the following exercise: ____

Family History Is there a family history *(blood relatives)* of: *(Please indicate the family member)*
☐Alzheimer's ____________________________
☐Arthritis _______________________________
☐Bleeding Disorder _______________________
☐Blood Clot______________________________
☐Cancer _________________________________
☐Cataracts _______________________________
☐Circulation Problems _____________________
☐Depression _________________________________
☐Diabetes ___________________________________
☐Emphysema_________________________________
☐Heart Disease _______________________________
☐High Blood Pressure__________________________
☐Neurological _________________________________
☐Strokes _____________________________________

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*
Cardiovascular: ☐Leg pain when walking ☐Fever ☐Chest Pain/Pressure ☐Leg Swelling ☐Cold Hand/Feet ☐Fainting ☐Palpitations ☐Vascular Disease ☐Valve Problems ☐**NONE**
Genitourinary: ☐Blood in Urine ☐Incontinence ☐Increased Urgency ☐Decreased frequency ☐Excessive Urination ☐Kidney Disease ☐Kidney Stones ☐ **NONE**
Gastrointestinal: ☐Abdominal Pain ☐Heartburn ☐Blood in Stool ☐Vomiting ☐Ulcers ☐Constipation ☐Diarrhea ☐Trouble Swallowing ☐Decreased Appetite ☐Increased Appetite ☐ **NONE**
Integumentary: ☐Athletes Foot ☐Nail Abnormalities ☐Keloids ☐Itchiness ☐Dry, Scaly Skin ☐ **NONE**
Hematologic: ☐Lower Leg Ulcers ☐Sickle Cell Disease ☐Anemia ☐Blood Thinners ☐Clotting Disorders ☐ **NONE**
Neurological: ☐Tingling ☐Weakness ☐Seizures ☐Numbness ☐Headaches ☐Tremors ☐Paralysis ☐**NONE**
Musculoskeletal: ☐Back Pain ☐Joint Swelling ☐Muscle Weakness ☐Muscle Pain ☐Neck Pain ☐Sciatica ☐Joint Stiffness ☐Joint Pain ☐Joint Instability ☐Arthritis ☐**NONE**
Respiratory: ☐Chest Pain ☐Wheezing ☐ COPD ☐Cough ☐Snoring ☐Shortness of Breath ☐Emphysema ☐**NONE**

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:** ___________________________