PATIENT INTAKE FORM

Date: _____ **Chart Number:** _____

First Name: _____ **Last Name:** _____ **MI:** ____

DOB: _____/_____/_____ **Gender:** _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip Code**_____

Home Phone: _____ **Work**: _____ **Cell:** _____

Email: _____ **Preferred Method of Contact:** _____

Primary Doctor or Referring Physician: _____ **Date Last Seen:** ____/_____/_____

Pharmacy: _____

Whom may we thank for referring you? _____

Emergency Contact:

Name: _____ **Relationship:** _____

Home Phone:_____ **Cell:**_____ **Work:**_____

Reason for Today's Visit/How can we help you?_____

_____

_

Where is the pain, discomfort or problem located? _____

How long has it been present? _____

Please describe your symptoms. _____

Can you describe how it started? _____

Has anything made it better or worse? _____

Have you seen anyone else about the problem?_____

What have you tried at home? _____

What is your goal for your visit with us? _____

What is your shoe size? _____

Do you have custom molded orthotics? ____ Do you have over the counter inserts? _____

Patient Name: _____

Past Medical History

Please check Yes or No:

Anemia	Yes_____ No_____	Peripheral Vascular disease	Yes_____ No_____
Anxiety	Yes_____ No_____	Psoriasis	Yes_____ No_____
Cancer	Yes_____ No_____	Psoriatic arthritis	Yes_____ No_____
Cardiac Disease	Yes_____ No_____	Psychiatric Care	Yes_____ No_____
Cataracts	Yes_____ No_____	Rheumatoid Arthritis	Yes_____ No_____
Chronic Renal Disease	Yes_____ No_____		
Congestive Heart Failure	Yes_____ No_____	Stroke	Yes_____ No_____
COPD	Yes_____ No_____	Ulcers	Yes_____ No_____
Depression	Yes_____ No_____		
Diabetes	Yes_____ No_____		
Gout	Yes_____ No_____	**Foot & Ankle History**	
Heart Burn	Yes_____ No_____	Bunion	Yes_____ No____
Hepatitis	Yes_____ No_____	Hammer toes	Yes_____ No____
High Cholesterol	Yes_____ No_____	High arch	Yes_____ No____
Hypertension	Yes_____ No_____	Flat foot	Yes_____ No____
Hypothyroidism	Yes_____ No_____	Neuroma	Yes_____ No____
Kidney disease	Yes_____ No_____	Heel pain	Yes_____ No____
Heart Attack/MI	Yes_____ No_____	Achilles tendonitis	Yes_____ No____
Obesity	Yes_____ No_____	Ankle sprain	Yes_____ No____
Osteoarthritis	Yes_____ No_____	Foot ulcers	Yes_____ No____
Osteoporosis	Yes_____ No_____	Foot Surgery	Yes_____ No____
Parkinson's	Yes_____ No_____		

Other Known illnesses:

_____

_____

Social History

Alcohol consumption: none/socially/occasionally/daily

Smoking: Current smoker: _____ Yrs. Smoked: _____ Former Smoker: _____ Never Smoked: _____

Exercise: yes/no type of exercise:_____

Occupation/Job description: _____ Time spent standing/walking per day_____

Past Surgical History

Past Surgery(ies) with dates:

_____

_____

_____

Family History:

Are your parents living? Father Yes/No Mother Yes/No

Has any family member had any of the following (please indicate relationship):

Diabetes:_____ Cancer:_____

Heart Disease:_____ High Blood Pressure:_____

Kidney Disease:_____Stroke:_____

Arthritis: _____Blood Clots:_____

Other:_____

Medication and Dosages: (please provide list)

_____

_____

_____

Allergies:

Adhesive Tape ____ Codeine_____ Ibuprofen_____ Local Anesthetics_____ Aspirin_____

Sulfa Drugs_____ Penicillin_____ Iodine_____ Anticoagulant Therapy_____ Seafood_____ Nuts_____ Latex_____ Other (please specify)_____

Patient Signature:_____ Date:_____