

Practice:

Today's Date:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

*E-mail newsletters, reminders, statements, etc.* Emergency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to insured:  Spouse  Child  Self  other

Phone #: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to insured:  Spouse  Child  Self  Other

Phone #: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you find out about our practice?  Physician  Internet  Telephone book  Family member  Friend  
 Other: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_ Result of accident or work injury?  Yes  No

How long has this bothered you?  1  2  3  4  5  6  7  days  weeks  months  years

What treatments have you tried & have they been effective? \_\_\_\_\_

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? \_\_\_/10

The pain quality is:  burning  constant  dull  sharp  shooting  throbbing  tingling Other: \_\_\_\_\_

**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: \_\_\_\_\_

Practice:

Today's Date:

**Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Declined to specify

**Race:**  Asian  American Indian or Alaska Native  Black or African American  
 White  Native Hawaiian or other Pacific Islander  Declined to specify  Declined to specify

**Preferred Language:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_  
**Pharmacy Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date Last Seen:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date Last Seen:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Privacy Information Preferences**

Do you want to be exempt from public reporting?  Yes  No Can we send mail to the address on file?  Yes  No

Can we call the phone number on file?  Yes  No Can we leave voicemail on machine?  Yes  No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters?  Yes  No

If yes, please provide your e-mail address: \_\_\_\_\_

Who can we leave messages with?  Wife  Husband  Daughter  Son  Other:  
Name(s): \_\_\_\_\_

**Smoking Status**

Current Every Day  Smoker, Current Status Unknown  
 Current Some Day  Heavy Tobacco  Unknown If Ever  
 Former  Never  Light Tobacco  I decline to answer

**Vital Signs**

**Blood Pressure:** \_\_\_\_\_ / \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Current Medications**

No Known Medications  I take the following medications:

Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_

Use the back of this form if more room is needed

**Allergies**

No Known Allergies  No Known Drug Allergies

Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

Use the back of this form if more room is needed

**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 Advanced 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. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# History and Physical

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_

**Medical History:**

<input type="checkbox"/> Liver	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Stroke
<input type="checkbox"/> 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 joints?  Yes (where? \_\_\_\_\_)  No    Do you have an artificial heart valve?  Yes  No

## Social History

Do you smoke?  Yes  No If yes how many packs per day?  1  2  3  4  5 For how long? \_\_\_\_\_

Do you drink alcohol?  Yes, everyday (5-7 days/week)  Yes, occasionally/socially  No/Rarely

Substance abuse:  Yes, I have a current substance abuse problem. Please specify: \_\_\_\_\_

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 or  sitting

Do you exercise regularly?  No, I do not exercise regularly  Yes, I do the following regular exercise: \_\_\_\_\_

## Family History

Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Emphysema	_____
<input type="checkbox"/> Blood clot	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Neurological	_____
<input type="checkbox"/> Circulation problems	_____	<input type="checkbox"/> Strokes	_____
<input type="checkbox"/> Other (specify):	_____		

## Review of Systems

(Please check the box if you currently have any of these symptoms or check "NONE")

<b>Cardiovascular</b>	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE	
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency		
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE	
<b>Gastrointestinal</b>	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE	
<b>Integumentary</b>	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> NONE
<b>Hematologic</b>	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> NONE
<b>Neurological</b>	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches	<input type="checkbox"/> NONE
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis				
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis	<input type="checkbox"/> NONE
<b>Respiratory</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	<input type="checkbox"/> NONE
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema				

## PLEASE READ AND SIGN

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_