PATIENT INTAKE FORM **Date:** ____________________

Chart #__________________________

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? ____

<u>Insurance Information</u> Do you plan to use insurance to pay for today's visit? Yes___ No___

Insurance Plan: ____

Insurance ID:____

Relation to Insured: Self___ Spouse___ Child___

<u>Emergency Contact:</u>

Name: _______________________________________ Relationship: ______________________

Home Phone:______________________ Cell:_________________________ Work:________________

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

____

Whereis 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 for the problem?____

What have you tried at home?____

What is your goal for you visit with us? ____

What is your shoe size? ____

Are you wearing custom molded orthotics? Yes___ No___

Are you wearing cover the counter inserts? Yes___ No___

Past Medical History

Please check Yes or No:

Alzheimers	Yes_____	No_____	Peripheral Vascular disease	Yes_____	No_____
Anemia	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_____	Skin cancer	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_____			
Cancer	Yes_____	No_____			
Heart Burn Reflux	Yes_____	No_____			
High Cholesterol	Yes_____	No_____			
Hypertension	Yes_____	No_____			
Hypothyroidism	Yes_____	No_____			
Kidney disease	Yes_____	No_____			
Heart Attack/MI	Yes_____	No_____			
Obesity	Yes_____	No_____			
Osteoarthritis	Yes_____	No_____			
Osteoporosis	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:

____
____
____

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)____________________________

Is there any other information that you would like for us to be aware of?:

____
____
____
____