

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: \_\_\_\_\_

## History and Physical

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

**Medical History:** ☐ Alcoholism ☐ Blood disorders ☐ 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 ☐ Cancer ☐ Hepatitis  
☐ Neuropathy (specify) \_\_\_\_\_ ☐ Thyroid disease (specify) \_\_\_\_\_ ☐ Diabetes (type 1, type 2)  
☐ Arthritis (specify) \_\_\_\_\_ ☐ other (specify) \_\_\_\_\_ ☐ HIV ☐ CVA  
**Are you pregnant?** ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

**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"/> diarrhea              | <input type="checkbox"/> trouble swallowing  | <input type="checkbox"/> decrease appetite   | <input type="checkbox"/> increase appetite | <input type="checkbox"/> constipation       |
| <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"/> tremors               | <input type="checkbox"/> paralysis           |                                              |                                            | <input type="checkbox"/> NONE               |
| <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"/> shortness of breath   | <input type="checkbox"/> emphysema           |                                              |                                            | <input type="checkbox"/> 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.

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Practice:

Today's Date:

|                                      |                                             |                                                                    |                                                    |
|--------------------------------------|---------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------|
| <b>Name:</b> _____                   |                                             | <b>Chart #:</b> _____                                              | <b>Date of birth:</b> _____                        |
| <b>Ethnicity:</b>                    | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino                    | <input type="checkbox"/> Declined to specify       |
| <b>Race:</b>                         | <input type="checkbox"/> Asian              | <input type="checkbox"/> American Indian or Alaska Native          | <input type="checkbox"/> Black or African American |
|                                      | <input type="checkbox"/> White              | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Declined to specify       |
| <b>Preferred Language:</b> _____     |                                             |                                                                    | <input type="checkbox"/> Declined to specify       |
| <b>Pharmacy Name:</b> _____          |                                             | <b>Pharmacy Phone:</b> _____                                       |                                                    |
| Pharmacy Address: _____              |                                             | City, State, Zip: _____                                            |                                                    |
| <b>Primary Care Physician:</b> _____ |                                             | Phone: _____                                                       | Date Last Seen: _____                              |
| Address: _____                       |                                             |                                                                    |                                                    |
| <b>Referring Physician:</b> _____    |                                             | 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: \_\_\_\_\_