

# Patient Information Sheet

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Main Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ relation \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Sex: M F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Sz: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Street: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**\*If the insurance holder is someone other than yourself (Parent, Spouse, Guardian or Other) or the patient is under the age of 18, please fill out the information below to allow us to file your insurance correctly\***

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ \*MI: \_\_\_\_\_  
\*Street: \_\_\_\_\_ \*City/State: \_\_\_\_\_ \*Zip: \_\_\_\_\_  
\*Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
\*Insurance Holder's Birthdate: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
\*Employer: \_\_\_\_\_ \*Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
\*Responsible Party (if other than patient) ----- \*Relationship to the patient? \_\_\_\_\_

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How did you hear about us? Newspaper \_\_; Radio \_\_; TV \_\_; Internet/Phone book \_\_; Other \_\_

Patient Referral \_\_\_\_\_

Physician Referral \_\_\_\_\_

Family Physician: \_\_\_\_\_ or Clinic: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Please list your current medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? Yes No If yes, please specify \_\_\_\_\_

\_\_\_\_\_

What is your current foot problem: \_\_\_\_\_

\_\_\_\_\_

How long has your problem been present?

Few days week 2-3 weeks month longer

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How would you describe your pain?

Sharp aching throbbing burning shooting numbness pins and needles other

Have you attempted any treatments to relieve your problem? Yes No if yes, please mark below all that applies:

Rest ice heat OTC padding change stretching OTC anti-inflammatory medication (Motrin, Alieve, Tylenol, etc.)

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**Please complete the following questions regarding your current and past medical history.**

**What is your activity level at work?**

Sitting standing walking considerable movement retired

Do you:

Smoke Yes No packs per day\_\_\_\_\_ Drink alcohol Yes No drinks per day\_\_\_\_\_ or Occasional

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**Current medical condition; please circle all that may apply.**

**Do you have:**

**Cardiovascular:**

High blood pressure  
Heart attack  
Irregular heart beats  
Pacemaker  
Chest pain  
Rheumatic fever  
Angina  
Angioplasty  
Heart murmur  
Open heart/bypass surgery

**Respiratory:**

asthma  
bronchitis  
emphysema  
shortness of breath  
tuberculosis  
pneumonia  
collapsed lung  
lung cancer

**Vascular/Circulation:**

blood clot/deep vein  
varicose veins  
blocked arteries  
thrombosis  
circulation disorder  
leg pain  
phlebitis  
high cholesterol

**Neurological:**

seizures  
numbness  
headaches  
stroke  
polio  
muscle weakness  
neuro-muscle disease  
tremor  
change in memory  
Sciatica

**Vision:**

Impaired vision  
Macular degeneration  
Cataracts  
Frequent infections  
Glaucoma

**Hearing:**

hearing loss  
frequent infections  
dizziness  
loss of balance

**Throat:**

frequent infections  
difficulties with speech  
hoarseness  
swollen nodes/glands

**Nose:**

sinus/allergies  
frequent nose bleeds  
deviated septum  
nasal polyps

**Gastrointestinal:**

**Heart burn/reflux**

Ulcer  
Hepatitis A  
Abdominal pain  
Gallbladder problems  
Hepatitis B  
Liver disorder  
Colitis  
Hepatitis C  
Loss of appetite  
Excessive thirst

**Genitourinary:**

**renal failure**  
renal dialysis  
kidney stone  
frequent bladder infections  
frequent urination  
gonorrhea  
syphilis  
chlamydia  
HIV  
herpes  
Ovarian Cancer  
Prostrate Cancer

**Hematological:**

**anemia**  
sickle cell disease or trait  
cancer/leukemia  
blood transfusions

**Endocrine:**

**diabetes**  
Thyroid disease

**Integument:**

skin rash  
skin growth  
psoriasis  
eczema  
skin cancer  
hives  
discolored moles

Are you currently taking any blood thinners? Yes No if yes, please circle all that may apply:

Coumadin Heparin Aspirin Plavix Other

**Muskoskeletal: Do you have/have you had any of the following:**

Arthritis/degenerative joint disease rheumatoid arthritis gout back pain hip pain knee pain  
Frequent muscle/tendon/pain

**Joint replacements/prosthesis:** hip knee ankle spine hands feet

**Childhood:** Have you had any of the following?

Rheumatic fever measles mumps chickenpox herpes/cold sores

**Psychiatric - Do you have:**

Depression anxious/agitation memory loss concentration difficulties suicidal nervousness  
Phobias bipolar disease felling of worthlessness/low self esteem

**Immunology – Do you have:**

HIV Frequent infections/weak immune system chronic fatigue syndrome/Ebstein Barr

**Family History – Does/did your Mother/Father/Siblings have any of the following? Please circle all that may apply:**

High blood pressure CVA/Stroke Cancer Diabetes Circulation problems other

Please specify if other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list any past surgical procedures you have had and the approximate month/year:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Complications if any:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have answered these questions truthfully and to the best of my knowledge.

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