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Patient Registration

Patient Information

Patient Full Name: ..Mr. ..Mrs. ..Ms. ..Dr.	Last	First	M.I.	...M ...F
By what name do you preferred to be addressed?		Single ‘	Married ‘	Divorced ‘ Separated ‘ Widowed ‘ Partner ‘
Patien W Address				
City		State		Zip
Preferred Phone ‘ Home ‘ Cell ‘ Work		Alternative Phone ‘ Home ‘ Cell ‘ Work		
E-mail Address (required for access to your online patient portal)				
Social Security #	Birth Date	I would like automated reminders by: ‘ Email ‘ Phone ‘ Text (Choose up to 3)		
Employer		Occupation		
Emergency Contact/Relationship		Phone		

Insurance

Patient is: ‘ Subscribe U Spouse ‘ Dependent		
Name of insured (if other than self)	Birth Date	SSN
Name of insured employer	Insured work phone number	
Name of person responsible for paying the bill (the Guarantor): ...Same as patient ...Same as insured		
Guarantor Address ...Same as patient ...Same as insured		
Guarantor Telephone		

L&I Injury

If injured on the job, fill this portion out.

Date of Injury	Type of Injury ‘ Work ‘ Auto ‘ Other	
Has a claim been filed? Yes ‘ No Claim#:	Where was claim filed?	
Cause of injury		

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Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ Date: _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

_____

_____

_____

Symptoms of Current Problem (circle or fill in your answer)

Which Side: Right Left Both Type of Pain: Dull Achy Throbbing Burning Sharp Shooting

Area of Pain: Bottom of Heel Back of heel Arch Ball of foot Big toe Top of foot Ankle No Pain

Other/Details: _____

On set: Slow Sudden Traumatic Has pain gotten: Better Worse Stayed the Same

How long has this been a problem for you?: Days Weeks Months Years

What aggravates condition? Walking Running Standing Shoes Activities First steps after rest

Other: _____ Severity: Mild Moderate Severe

What have you tried for the pain? Changing shoes Anti-inflammatory meds Decreasing activities Ice Heat Prefabricated Arch Supports Custom Orthotics Stretching Injections Physical Therapy Surgery Antibiotics Other OTC Meds Taping Massage Acupuncture Soaking

Other: _____

After it starts, how long does pain last? _____

Have you ever had a similar pain? (describe, including treatments received) _____

_____

How did you hear about our office?

☐ Relative ☐ Friend ☐ Google ☐ Bing ☐ Other Web Search ☐ Facebook ☐ Yelp

☐ Insurance Company ☐ Mail ☐ Phone Book ☐ TV ☐ Other: _____

☐ From My Doctor (name/specialty/city): _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ ☐ MD ☐ DO ☐ PN

Date last seen: _____ ☐ I don't have a primary care physician

Other doctors and their specialties: _____

_____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

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NAME: _____ DATE: _____

Past Medical History, Social and Family History Form

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

† Adhesive/Tape † Aspirin
† Codeine † Iodine
† Local Anesthetics † Penicillin
† Seafoods † Sulfa
† Other: _____
† No Known Allergies

Medications

List all medications (and doses) you are taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

_____
_____
_____
_____
_____
_____
_____
_____

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family
yes	no	Anemia	yes
yes	no	Arthritis: Type: _____	yes
yes	no	Artificial Heart Valve or Joints	yes
yes	no	Asthma	yes
yes	no	Back Problems	yes
yes	no	Bleed easily	yes
yes	no	Cancer	yes
yes	no	Chemical Dependency	yes
yes	no	Chest Pain	yes
yes	no	Circulatory Problems	yes
yes	no	Diabetes	yes
yes	no	Epilepsy	yes
yes	no	Fibromyalgia	yes
yes	no	Gout	yes
yes	no	Heart Disease	yes
yes	no	Hemophilia	yes
yes	no	Hepatitis	yes
yes	no	High Blood Pressure	yes
yes	no	HIV Positive	yes
yes	no	Kidney Problems	yes
yes	no	Leg Cramps	yes
yes	no	Liver Disease	yes
yes	no	Lung/Respiratory	yes
yes	no	Menopause	yes
yes	no	Mental Illness	yes
yes	no	Phlebitis / Clots	yes
yes	no	Psoraisis	yes
yes	no	Rheumatic Fever	yes
yes	no	STD	yes
yes	no	Stroke	yes
yes	no	Thyroid Problems	yes
yes	no	Tuberculosis	yes
yes	no	Ulcers/Stomach	yes
yes	no	Weight Change	yes

Mental / Emotional

yes no Eating Disorder
yes no Anxiety
yes no Depression
yes no Psychiatric
yes no Alcoholism

Exercise and Orthotics

In what athletic activities do you participate?

_____

days per week exercising? _____
Do you wear store-bought arch supports? yes no
Do you wear custom orthotics? yes no
If yes, who made them: _____
How old are the orthotics: _____

Social History

Your occupation?

_____

Do you smoke? yes no
Are you a past smoker? yes no
How Much? packs/day _____
Years Smoked: _____

Drink Alcohol?: yes no
How Much: _____

Recreational Drugs? yes no
What: _____

Pregnant or possibly pregnant? yes no

The US HITECH Act requires us to ask the following questions:

Preferred Language: † English
† Other: _____

Race: † American Indian or Alaska native
† Asian † Asian Indian
† Black/African American
† European
† Native Hawaiian/Pacific Islander
† White
† Other: _____
† Decline

Ethnicity: † Hispanic/Latino
† Not Hispanic/Latino
† Other: _____
† Decline

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Review of Symptoms

Check all that you are currently experiencing.

GENERAL

- † Fever
- † Chills
- † Sweats
- † Weight Loss
- † Weight Gain
- † Other_____

EYES

‡Please circle right, left or both

- ☐ Vision changes R L Both
- ☐ Eye injury R L Both
- ☐ Eye irritation R L Both
- ☐ Other_____

EARS/Nose/Throat

‡Please circle right, left or both

- ☐ Hearing loss R L Both
- ☐ Earache R L Both
- ☐ Smell Disorder
- ☐ Balance problem
- ☐ SoreThroat
- ☐ Other_____

CARDIOVASCULAR

- † Chest Pain
- † Irregular beat
- † Heart Valve problems
- † Edema
- † Other_____

RESPIRATORY

- † Cough
- † Difficulty sleeping
- † Wheezing
- † Other_____

GASTROINTESTINAL

- † Nausea
- † Vomiting
- † Diarrhea
- † Abdominal pain
- † Other_____

GENITOURINARY

- † Pain with urination
- † Frequent urination
- † Difficulty starting or maintaining urination
- † Other_____

MUSCULOSKELETAL

- † Muscle cramps or aches
- † Joint pain or swelling
- † Back pain
- † Other_____

CIRCULATION

- † Leg cramps
- † Blood Clots
- † Other_____

NEUROLOGICAL

- † Headaches
- † Seizures/Stroke
- † Numbness/Tingling
- † Other_____

PSYCHOLOGICAL

- † Depression
- † Anxiety
- † Other

ENDOCRINE

- † Cold intolerance
- † Heat intolerance
- † Excessive thirst or urination
- † Other_____

HEMATOLOGICAL

- † Abnormal bruising
- † Abnormal bleeding
- † Other_____

SKIN

- † Rash
- † Itching
- † Suspicious lesions
- † Other_____

I haveanswered the above questions to the best of my ability. By typing your name below, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature/e-Signature_____ Date:_____/_____/_____

*Note: Your e-signature does act as your real signature