Patient Registration

Patient Information

Patient Full Name: **Last** **First** **M.I.** ☐ **M** ☐ **F**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

By what name do you preferred to be addressed?

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐

Patient's 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)

[redacted]

Birth Date

I would like automated reminders by: ☐ Email ☐ Phone ☐ Text (Choose up to 3)

Employer **Occupation**

Emergency Contact/Relationship **Phone**

Insurance

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Dependent**

Name of insured (if other than self) **Birth Date** [redacted]

Name of insured's employer **Insured's work phone number**

Name of person responsible for paying the bill (the Guarantor):
☐ **Same as patient** ☐ **Same as insured**

Guarantor's Address
☐ **Same as patient** ☐ **Same as insured**

Guarantor's 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

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 Padding 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): _____

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

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
- Sore Throat
- 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 have answered 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