
**NEW PATIENT INTAKE INFORMATION**

**Patient Name:** _____ **Date of Birth:**_____

**Address:**_____

**____ Facility ___Home _____ Assisted ____Nursing Home ____ Independent**

**Power of Attorney/Caregiver/Guardian:** _____

**Contact phone number:** _____

**INSURANCE: Medicare # :** _____

**Secondary #:** _____

**Other/Self Pay:** _____

**Address for self pay billing:** _____

**Primary Care Physician:** _____

**PCP Phone number:** _____

**Last Hospital or ED visit and location:** _____

**Signature of patient/guardian/POA:** _____**Date** _____

**PATIENT INTAKE FORM**

**Date:** _____ **Chart Number:** _____

**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?** _____

**Emergency Contact:**

**Name:** _____ **Relationship:** _____

**Home Phone:**_____ **Cell:**_____ **Work:**_____

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

_____

_

Where is 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 about the problem?_____

What have you tried at home? _____

What is your goal for your visit with us? _____

What is your shoe size? _____

Do you have custom molded orthotics? ____ Do you have over the counter inserts? _____

**Patient Name:** _____

**Past Medical History**

**Please check Yes or No:**

| | | | |
|---|---|---|---|
| Anemia | Yes_____ No_____ | Peripheral Vascular disease | Yes_____ No_____ |
| Anxiety | 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_____ | | |
| Congestive Heart Failure | Yes_____ No_____ | Stroke | Yes_____ No_____ |
| COPD | Yes_____ No_____ | Ulcers | Yes_____ No_____ |
| Depression | Yes_____ No_____ | | |
| Diabetes | Yes_____ No_____ | | |
| Gout | Yes_____ No_____ | **Foot & Ankle History** | |
| Heart Burn | Yes_____ No_____ | Bunion | Yes_____ No____ |
| Hepatitis | Yes_____ No_____ | Hammer toes | Yes_____ No____ |
| High Cholesterol | Yes_____ No_____ | High arch | Yes_____ No____ |
| Hypertension | Yes_____ No_____ | Flat foot | Yes_____ No____ |
| Hypothyroidism | Yes_____ No_____ | Neuroma | Yes_____ No____ |
| Kidney disease | Yes_____ No_____ | Heel pain | Yes_____ No____ |
| Heart Attack/MI | Yes_____ No_____ | Achilles tendonitis | Yes_____ No____ |
| Obesity | Yes_____ No_____ | Ankle sprain | Yes_____ No____ |
| Osteoarthritis | Yes_____ No_____ | Foot ulcers | Yes_____ No____ |
| Osteoporosis | Yes_____ No_____ | Foot Surgery | 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:

_____

_____

_____

**Family History:**

Are your parents living? Father Yes/No Mother Yes/No

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)_____

Patient Signature:_____ Date:_____