

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: \_\_\_\_\_



<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> _____	
<b>Pharmacy Address:</b> _____		<b>City, State, Zip:</b> _____	
<b>Primary Care Physician:</b> _____		<b>Phone:</b> _____	<b>Date Last Seen:</b> _____
<b>Address:</b> _____			
<b>Referring Physician:</b> _____		<b>Phone:</b> _____	<b>Date Last Seen:</b> _____
<b>Address:</b> _____			

**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

**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: \_\_\_\_\_



# History and Physical

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

**Medical History:**

<input type="checkbox"/> Liver	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA	
<input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> 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
<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
<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
<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

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Patient Signature: \_\_\_\_\_

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