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)

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: ☐ **Subscriber** ☐ **Spouse** ☐ **Dependent**

Name of insured (if other than self) **Birth Date** **SSN**

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

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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 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): _____

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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**

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