Patient name: ______________________________ Date of Birth: _______________

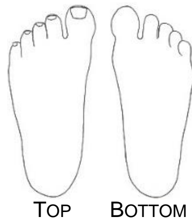
Current Problem

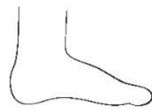
What specific problem brings you to the office today?

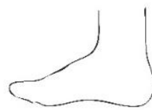
____

Where is the pain/problem located? Please mark on the pictures below:

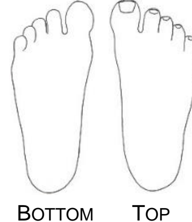
Left

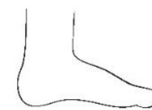






Right





When did this problem begin? ____

How did this problem occur (was there an injury)? ____

What treatments have you had for this problem? ____

Your medical history

Height: __________ Current weight: _________ Shoe size: ________

Do you currently have or have you had any of the following?

☐ Diabetes	☐ Blood clots or phlebitis	☐ Cancer	☐ Gout
☐ High cholesterol	☐ Bleeding disorders	☐ Hepatitis	☐ Asthma
☐ High blood pressure	☐ Circulation problems	☐ Thyroid disorder	☐ GI/stomach ulcer
☐ Heart attack	☐ Stroke	☐ Arthritis	☐ Back pain
☐ Artificial heart valve	☐ Kidney problems	☐ Joint implant	☐ Seizures

☐ Other: ____

Please list all medications you are currently taking and the dose. You may provide a separate list (Include prescriptions, over-the-counter meds and herbal supplements):

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Have you ever experienced any allergic reactions or adverse effects from any of the following? (Check all that apply) ☐ **No known drug allergies**

☐ Penicillin	☐ Aspirin	☐ Sulfa drugs	☐ Codeine
☐ Morphine	☐ Novocaine	☐ Iodine	☐ IV contrast
☐ Latex	☐ Metal	☐ Tape	☐ Lactose

☐ Other: ____

(Please see next page)

PATIENT NAME: ________________________________ DATE OF BIRTH: ________________

PLEASE LIST ALL PRIOR SURGERIES: (TYPE OF SURGERY AND DATE)

____ ____
____ ____
____ ____
____ ____

SOCIAL HISTORY

EMPLOYER: _________________________ OCCUPATION: ___________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO YOU EXERCISE? ☐ NEVER ☐ 1 DAY/WEEK ☐ 2-3 DAYS /WEEK ☐ 4-5 DAYS/WEEK ☐ 6-7 DAYS/WEEK

TYPE OF EXERCISE: ____

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ABUSE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ______________ TYPE ___________________
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO ANY OF YOUR FAMILY MEMBERS HAVE THE FOLLOWING CONDITIONS?

	MOTHER	FATHER
DIABETES	☐	☐
CANCER	☐	☐
STROKE	☐	☐
HEART DISEASE	☐	☐
HIGH BLOODO PRESSURE	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
OTHER	☐ ________	☐ _________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____________________________________ _____________________________________
PRINT NAME OF PATIENT RELATIONSHIP TO PATIENT (IF PARENT OR GUARDIAN)

____
SIGNATURE DATE