

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ ID # _____ GROUP # _____

EMPLOYER _____ ADDRESS: _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ ID # _____ GROUP # _____

EMPLOYER _____ ADDRESS: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

NAME OF SPOUSE/PARTNER, IF APPLICABLE: _____

ADDRESS OF SPOUSE/PARTNER, IF APPLICABLE: _____

CHILDREN: NAMES	DATE OF BIRTH	MALE/FEMALE
_____	_____	M F
_____	_____	M F
_____	_____	M F
_____	_____	M F

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE 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 _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____ ADDRESS: _____

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

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY
TYPES OF EXERCISE: _____

FAMILY MEDICAL HISTORY

DO YOU HAVE A FAMILY HISTORY OF:	FAMILY MEMBER:	DO YOU HAVE A FAMILY HISTORY OF:	FAMILY MEMBER:
CANCER		HIGH BLOOD PRESSURE	
CORONARY ARTERY DISEASE		RHEUMATOID ARTHRITIS	
DIABETES		STROKE	
HEART DISEASE		THYROID DISEASE	

OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: NONE KNOWN MEDICATIONS _____
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y N	FIBROMYALGIA	Y N	NEUROPATHY	Y N
ANEMIA	Y N	GOUT	Y N	OPEN SORES	Y N
ARTHRITIS	Y N	HEART ATTACK	Y N	PNEUMONIA	Y N
ASTHMA	Y N	HEART DISEASE/FAILURE	Y N	POLIO	Y N
BACK TROUBLE	Y N	HEPATITIS	Y N	RHEUMATIC FEVER	Y N
BLADDER INFECTIONS	Y N	HIV+/AIDS	Y N	SICKLE CELL DISEASE	Y N
ABNORMAL BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N	SKIN DISORDER	Y N
BLOOD CLOTS	Y N	KIDNEY DISEASE	Y N	SLEEP APNEA	Y N
BLOOD TRANSFUSION	Y N	LIVER DISEASE	Y N	STOMACH ULCERS	Y N
BRONCHITIS/EMPHYSEMA	Y N	LOW BLOOD PRESSURE	Y N	STROKE	Y N
CANCER	Y N	MIGRAINE HEADACHES	Y N	THYROID DISEASE	Y N
DIABETES	Y N	MITRAL VALVE PROLAPSE	Y N	TUBERCULOSIS	Y N

OTHER CONDITIONS: _____

WOMEN: ARE YOU PREGNANT YES NO IF SO, HOW MANY MONTHS? _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOPED OVER TIME

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED
WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES RESTING RUNNING
 DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

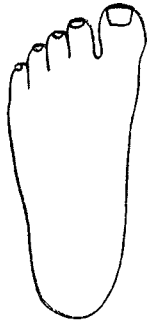
WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

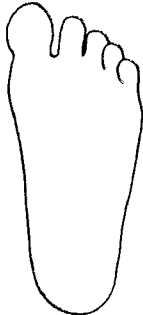
WAS THIS PROBLEM CAUSED BY AN INJURY? NO YES (DESCRIBE) _____
IF YES, WAS IT A WORK-RELATED INJURY? YES NO

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



BOTTOM OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

I HEREBY AUTHORIZE FOOT & ANKLE ASSOCIATES, LTD. TO TREAT ME IN ANY WAY THAT IS APPROPRIATE AND TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT. 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. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME AND MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY MEDICAL BILLS NOT PAID BY MY INSURANCE CARRIER.

PATIENT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE OF DOCTOR DATE