New Patient Form

Keeping Feet in *Motion*

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Primary Care Physician: _____ Last Visit w/ PCP: _____

Endocrinologist: _____ Last Visit w/ Endo: _____ Referred by: _____

Please describe your problem (include date of injury if applicable) : _____

_____

_____

_____

PAST MEDICAL HISTORY

Check all that apply:

	Frequent Headache/Migraine		Anemia / Blood Disorders
	Rheumatic Fever		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis MWF or T TH Sa		Epilepsy / Seizures
	Diabetes Average Blood Sugar:		Prolonged Bleeding Time
	Tuberculosis		Stomach Disorder
	Emphysema		Thyroid / Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems / Tension
	BLOOD CLOTS		Asthma / Hay Fever / Shortness of Breath
	Tumor / Abnormal Growth / Cancer		Prostate Disorder
	Ear / Nose / Throat Disorder		Sexually Transmitted Disease

Has any FAMILY MEMBER had any of the following problems (Please indicate relationship):

Cancer: _____ Diabetes: _____ Heart Trouble: _____

High Blood Pressure: _____ Kidney Disease: _____ Stroke: _____

Mental or Emotional Disease: _____ Tuberculosis: _____

Arthritis: _____ Emphysema: _____ BLOOD CLOTS: _____

PATIENT INFORMATION

Do you currently smoke? ___No ___Yes If yes, how many packs/day?_____ How many Years?_____

Smoke previously? __No __Yes If yes, how many packs/day? ____ How many years? ___ Year Quit:____

Number of caffeine drinks per day: _____ Amount of alcohol consumed per week? _____

Please complete the following: Occupation: _____

Shoe Size: _____ Height: _____ Weight: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Other: _____

Exercise Type/Duration/ Frequency (Example: Walk 10 minutes 3X per week): _____

_____

ALLERGIES

Please check all allergies:

_____ Medications: _____

_____ Foods: _____

____ Tapes ___ Novocain ___ Anesthetics ___ Silver/Nickel/Costume Jewelry ___ Other: _____

What types of reactions have you experienced? _____

_____

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages: _____

_____

_____

_____

_____

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

HEALTH REVIEW

Please check any symptoms you have had in the past 3 months:	
General	☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss ☐ Weight Gain
Head	☐ Headaches ☐ Visual Problems ☐ Hearing Problems ☐ Light Sensitivity
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Swelling of Legs ☐ Other
Hematology	☐ Anemia ☐ Abnormal Bleeding/Bruising ☐ Blood Clots ☐ Other Blood Disorder
Respiratory	☐ Persistent Cough ☐ Wheezing ☐ Shortness of Breath
Gastrointestinal	☐ Difficulty Swallowing ☐ Indigestion/Heartburn ☐ Abdominal Pain ☐ Change in Bowel Habits
Urinary	☐ Painful Urination ☐ Frequent Night-time Urination ☐ Bladder Leakage ☐ Other
Musculoskeletal	☐ Join Pain/Swelling/Stiffness ☐ Back Pain ☐ Arthritis ☐ Muscle Weakness
Skin	☐ Skin Rash ☐ Suspicious Lesions ☐ Itching
Neurological	☐ Numbness of hands/feet ☐ Seizures ☐ Tremors ☐ Paralysis
Psychiatric	☐ Depression ☐ Anxiety ☐ Problems Sleeping ☐ Memory Loss
Endocrine	☐ Heat/Cold Intolerance ☐ Hot Flashes ☐ Change in hair/skin texture ☐ Other

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Patient Signature: _____ Date: _____

I have personally reviewed the above information:

Patient Signature: _____ Date: _____