CERTIFIED FOOT CARE

Date:

Name: _____ **DOB**: _____ **Phone**: _____

Address: _____ **E-mail**: _____

Emergency Contact:_____ Phone: _____

What is the reason for your visit today? :

_____

Result of accident or work injury? Y/N How long has this bothered you?_____

What treatments have you tried and have they been effective? _____

On a scale of 1-10, what is your level of pain? ___/10

Pharmacy Name & Address : _____

Primary Care Doctor: _____ Date Last Seen:_____

Height : _____ **Weight**:_____ **Shoe Size/Width**:_____

Blood Pressure:_____/_____ (most recent) **Glucose:**_____ (most recent)

Medications: _____

_____

_____

Allergies:

_____

Social History:

Do you smoke? __Y __N (How much and how long?_____)

Do you drink alcohol? __Y __N (How much and how long?_____)

Recreational Drugs? __Y __N (How much and how long?_____)

Do you exercise regularly? __Y __N If so what_____

Any falls within the last 6 months? __Y __N

Patients Signature: _____ Date: _____

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Medical History:

__Diabetes (Type 1, Type2) HbA1c: _____

__High Blood Pressure __Heart Murmur __Blood Clot __Heart Disease

__Circulation Problems __Blood Disorders __High Cholesterol __Neuropathy __Stroke

__Musculoskeletal __Sleep apnea __Arthritis __Gout __Acid Reflux __ Osteoporosis

__Thyroid __Cancer __Depression __Anxiety Disorder __Mental Illness __HIV

__Breathing Issues __Skin Disorders __Hepatitis __Liver

Hospitalizations within the last year? __Y __N Reason: _____

Surgical History:

__None __Appendectomy __C-Section __Angioplasty __Bypass __Cataracts

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? _Y_N

If yes, please describe: _____

Do you have any artificial joints? _Y _N (where?_____)

Do you have an artificial heart valve?_Y _N

Privacy Information Preferences

Can we call the number on file? __Yes __No Can we send mail to the address? __Yes __No

Can we leave voicemail? __Yes __No Who can we not leave message with:_____

Please Read and Sign: The information on my intake form 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. (*Assignments of Benefits*): I authorize payment of medical benefits to the practice named above.I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I authorize payment of health benefits otherwise payable to me, directly to my doctor. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I permit a copy of this authorization to be used in place of the original. I authorize release of any information related to any claims to all my insurance companies or other relevant parties. (*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 Doctor's office to retrieve my medication history.

Patients Signature: _____ Date: _____