Name: _______________________________ **D.O.B:**___________________ **Age:** __________ **Shoe Size:** ____________

Sex: □ M □ F **Marital Status:** □ Single □ Married □ Widowed □ Divorced **Social Security Number:** ______________

Address: ____ **City:** ______________ **State:** ___________ **Zip:**___________

Home Number: ___________________________ **Cell Number:** ___________________ **Other:** ____________________

Employer: _____________________________ **Employer Phone:** ______________________________

Primary Insurance: ________________________________ **Are you the policy holder?** □ **Yes** □ **No**

Subscriber ID: ______________________________ **Relationship to insured:** □ Self □ Spouse □ Child

Phone Number: ________________________ **Sex:** □ M □ F **Date of Birth:** ___________________________

Address: ____ **City:** _____________ **State:**__________ **Zip**_________

Policy ID: ________________________ **Group ID** ______________________ **Employer** _______________________

Secondary Insurance: ___________________________________ **Are you the policy holder?** □ **Yes** □ **No**

Subscriber ID: ______________________________ **Relationship to insured:** □ Self □ Spouse □ Child

Phone Number: ________________________ **Sex:** □ M □ F **Date of Birth:** ___________________________

Address: ____ **City:** _____________ **State:**__________ **Zip**_________

Policy ID: ________________________ **Group ID** ______________________ **Employer** _______________________

How did you found out about our practice? □ Billboard □ RSFC Website □ ValPak □ iHeart Radio

□ **Other:** ____

What is the reason for your visit? ____

Was this the result of an injury? □ **Yes** □ **No** **If yes, is it work related?** □ **Yes** □ **No**
If no, describe injury ____

How long has this bothered you? _______ □ **days** □ **weeks** □ **months** □ **years**

What treatments have you tried & have they been effective? ____
____

On a scale of 1-10 (1 being no pain / 10 being the worst) what is your level of pain? ________ **/ 10**

The pain quality is: □ burning □ constant □ dull □ sharp □ shooting □ throbbing □ aching

<u>Allergies</u>: □ **No Known Allergies**

Medication Allergies: **Allergy** ___________________________ **Reaction** ________________________

Allergy ___________________________ **Reaction** _________________________

Other allergies: ____

Review of Systems: (*Please check the box if you currently have any of these symptoms):*

Cardiovascular: □ leg pain when walking □ fever □ chest pain/pressure □ leg swelling □ cold hands/feet

□ fainting □ palpations □ vascular disease □ valve problems □ **NONE** □ **Other** ______________________

Genitourinary: □ blood in urine □ hesitancy □ incontinence □ increased urgency □ decreased frequency

□ excessive urination □ kidney disease □ kidney stones □ **NONE** □ **Other** ____________________________

Gastrointestinal: □ abdominal pain □ heartburn □ blood in stool □ vomiting □ ulcers □ constipation

□ diarrhea □ trouble swallowing □ decrease appetite □ increase appetite □ **NONE** □ **Other** __________________

Skin: □ athletes foot □ nail abnormalities □ keloids □ itchiness □ dry, scaly skin □ **NONE** □ **Other** ______________

Hematologic: □ lower leg ulcers □ sickle cell disease □ anemia □ blood thinners
□ clotting disorders □ **NONE** □ **Other** ___________________________

Neurological: □ tingling □ weakness □ seizures □ numbness □ headaches □ tremors
□ paralysis □ **NONE** □ **Other** __________________________

Musculoskeletal: □ back pain □ joint swelling □ muscle weakness □ muscle pain □ neck pain □ sciatica

□ joint stiffness □ joint pain □ joint instability □ arthritis □ **NONE** □ **Other** __________________________

Respiratory: □ chest pain □ wheezing □ COPD □ coughing □ snoring □ shortness of breath □ emphysema

□ **NONE** □ **Other** _____________________________

List all current *medications*:

Medication ____________________________ Dosage _________________ Times Per Day ______________________

Medication ____________________________ Dosage _________________ Times Per Day ______________________

Medication ____________________________ Dosage _________________ Times Per Day ______________________

Medication ____________________________ Dosage _________________ Times Per Day _______________________

Current Pharmacy ____

Social History:

Current smoker? □ No □ Yes **If yes, how many packs per day?** _____________ **For How Long?** _____________

Former Smoker? □ No □ Yes **If yes, how long ago did you quit?** _________________ **Packs per day?** ____________

Do you drink alcohol? □ Yes, occasionally/socially □ Yes, everyday □ No

If yes, what do you usually drink? □ Beer □ Wine □ Liquor

Do you exercise regularly? □ Yes □ No **If yes, what type of exercise?** ________________________________

Medical History:

□ Anemia □ Anxiety □ Arthritis □ Back Problems □ CAD □ CHF □ Cancer □ Cholesterol High □ Dementia

□ Diabetes □ Epilepsy □ GERD □ Glaucoma □ GOUT □ HIV □ Headaches □ Hepatitis □ Alzheimer's

□ Hypertension □ MI □ Heart Dz □ Pneumonia □ Renal Stone □ Stroke □ TB □ Ulcer (GI) □ Thyroid Dz

□ Neuropathy (*specify*) _________________________ □ Other ____

Are you currently pregnant? □ No □ Yes **Are you currently nursing?** □ No □ Yes

Surgical History:

□ None □ Transplant □ Angioplasty □ Bypass (*specify*) _______________ □ Other ___________________________

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

□ No □ Yes **If yes, please describe** ____

Do you have any artificial joints? □ No □ Yes **If yes, where** ____

Do you have an artificial heart valve? □ No □ Yes

***Family History:* Is there any family history (blood relative) of: (please indicate family member)**

□ Anxiety ____________________ □ Arthritis _________________ □ Cancer ________________

□ Cholesterol High ___________________ □ Dementia ____________________ □ Depression __________________

□ Diabetes ____________________ □ GOUT _____________________ □ Heart Disease ______________________

□ Hypertension ____________________ □ Neurological ___________________ □ Strokes ____________________

□ Other *(please specify)* ____

____

PLEASE READ AND SIGN

The above information 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 to all updates to the information above.

Signature _______________________________________

Date ______________________________