PLEASE COMPLETE ALL PARTS OF THIS FORM, IT IS IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS

Name: _____ Age: _____

Gender: Male/Female Height: _____ Weight:_____ Shoe Size:_____

Did you receive a vaccine for: ____ flu ____ pneumonia *Women only*: Are you pregnant? _____

Occupation: _____At your job you mostly: ___ Sit ___ Stand ___ Walk

What is the reason for your visit today?_____

What type of shoes do you typically wear?_____

How long has it been a problem (days, weeks, months, years)?_____

Is it getting better, staying the same, or is it worse?_____

How did it start, did you have an injury or any other inciting event/trauma?_____

Work related accident?_____ If so, date of accident?_____

What makes it better?_____ What makes it worse?_____

Do you have difficulty on uneven stairs or surfaces?_____

What treatment have you or another doctor tried, if any?_____

What activities do you participate in (sports, gardening, etc.)?_____

What is your level of pain?

No Pain				Moderate Pain					Worst Pain	
0	1	2	3	4	5	6	7	8	9	10

Past Medical History: Please circle if you have, or have ever had, any of the following:

High blood pressure	Hyperthyroid (high)	Cancer (type_____)
High cholesterol	Hypothyroid (low)	Anemia (type_____)
Heart attack/ MI /Stroke	Hormone gland problems	Bleeding problems
Heart disease	Hepatitis (type_____)	Retinopathy/Macular degeneration
Angina	Liver cirrhosis	Circulation problems
Heart failure	Liver jaundice	Blood clots in legs/lungs
Bypass surgery	Gallbladder disease	Arthritis (type_____)
Mitral Valve Prolapse	Kidney infection	Gout
Irregular Heart beat/Murmur	Kidney stones	Psoriasis
Seizures/Epilepsy	Kidney failure/insufficiency	Skin disorder
Nervous system disorder	Urinary/Bladder Infection	Immune disorder
Tuberculosis	Prostate disease	AIDS or HIV+
Asthma / Bronchitis	Gynecological disorders	Stomach bleeds/Intestinal disease
Pneumonia	Hiatal hernia	Gastro-esophageal reflux
Emphysema	Anxiety	Depression
Psychiatric disorders	Problems with anesthesia	Diabetes (_____ years diagnosed)

List any medical conditions not listed above: _____

Surgical History: Please list ALL surgeries and recent hospitalizations you have had & what year:

_____

_____