Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)		Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address ok to contact by Email? YES or NO

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Please describe any previous treatment and care you have received for this problem.

_____

_____

_____

_____

Pain Assessment

Indicate your level of pain on a scale of 1 - 10.

(10 = worst pain imaginable)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check the symptoms that best describe your problem.

☐ Stiffness ☐ Pain ☐ Instability ☐ Swelling

☐ Numbness ☐ Other: _____

Are your symptoms getting...

☐ Better Gradually ☐ Better Rapidly

☐ Worse Gradually ☐ Worse Rapidly

What **improves** your symptoms?

☐ Rest ☐ Ice ☐ Heat ☐ Motrin/ Aleve

☐ Other: _____

What makes your symptoms **worse**?

☐ Activity ☐ Cold

☐ Other: _____

Podiatry

Do you have any of the following?

☐ Ankle Sprain
☐ Arch Pain
☐ Athlete's Foot
☐ Broken Ankle
☐ Broken Foot Bones
☐ Bunions
☐ Burning in Feet
☐ Corns / Calluses
☐ Cramps in Feet
☐ Cramps in Legs
☐ Enlarged Veins
☐ Flat Feet
☐ Foot Numbness
☐ Foot Ulcers
☐ Fungal Nails
☐ High Arch Feet
☐ Heel Pain
☐ Hammer Toes
☐ Ingrown Nails
☐ In-toeing
☐ Knee Pain
☐ Leg Ulcers
☐ Loss of Sensation in Feet
☐ Lower Back Pain
☐ Rash on Feet
☐ Swelling in Ankles
☐ Swelling in Feet
☐ Swelling in Legs
☐ Tingling in Feet

Do you currently or have you ever worn orthotics?

☐ Yes ☐ No

Does your foot pain limit your desired activity?

☐ Yes ☐ No

Are your first steps out of bed in the morning painful?

☐ Yes ☐ No

Have you ever had any other foot problems?

☐ Yes ☐ No

If so, please describe: _____

_____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

How many hours a day do you stand?

# of hours _____

What type of shoes do you wear?

☐ Flat ☐ Heels ☐ Boots ☐ Loafers ☐ Oxfords

☐ Sandals ☐ Sneakers Other: _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex

☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine

☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Other Notes: