



PLEASE, tell us how you heard about our clinic
 Ad (name)?, doctor referral?, Signage? Friend?

First Name: _____ **Last Name:** _____ **Date:** _____
please no nick names

Address: _____ **City:** _____ **Postal:** _____

Age: _____ **Sex:** _____ **Weight:** _____ lbs **D.O.B:** _____ - _____ - _____
Day Month Year

Home: _____

E-mail: _____ **Work:** _____

Family Dr: _____ **Dr. Tel:** _____ **Cell:** _____

Insurance Co.: _____ **Primary Insured:** _____ **Employer:** _____

Current Complaint:	Allergies:
<input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Callous <input type="checkbox"/> Fungal Infection <input type="checkbox"/> Diabetic Foot Care <input type="checkbox"/> Corns <input type="checkbox"/> In-Grown Nails <input type="checkbox"/> Thick Nails <input type="checkbox"/> Warts <input type="checkbox"/> Painful Feet <input type="checkbox"/> Other: _____ <input type="checkbox"/> Orthotics / Shoes	_____ _____

Medical History:		
<i>Check off any of the following applicable to you</i>		
<input type="checkbox"/> Good General Health Cardiac <input type="checkbox"/> Hypertension <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Angina <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Cerebral Vascular Accident <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Other Heart Problems <input type="checkbox"/> Blood Disorders (e.g.: HIV, Hepatitis) Psychological _____	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis Endocrine <input type="checkbox"/> Thyroidism <input type="checkbox"/> Diabetes (Type I) yrs: _____ <input type="checkbox"/> Diabetes (Type II) yrs: _____ <input type="checkbox"/> Osteoporosis Dermatology <input type="checkbox"/> Psoriasis <input type="checkbox"/> Fungal <input type="checkbox"/> Other	Musculoskeletal <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back Condition _____ <input type="checkbox"/> Neuromuscular Disorder _____ Fractures _____ _____ Other _____

Medications	for	Medications	for

Past Surgeries	Year