

# Appointment & Question Form

Existing patients who wish to schedule an appointment, place product re-orders, or have questions only - go to the end of page 2. New patients, please fill out as much as possible from the top.

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex:  M  F \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Mr.  Mrs.  Sng \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email address \_\_\_\_\_ Cell Phone # \_\_\_\_\_ In case of Emergency \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ Phone# \_\_\_\_\_ Fax # \_\_\_\_\_  
May we contact your physician about your health? Yes \_\_\_ No \_\_\_ Date you last saw your doctor \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Do you take Coumadin  Aspirin  other  \_\_\_\_\_  yes  No How Long \_\_\_\_\_

## PRIMARY INSURANCE (ALL FIELDS MUST BE FILLED IN)

Person Responsible for Account \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_

## ADDITIONAL INSURANCE (IF APPLICABLE)

Insured name \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_

## REASON FOR TODAY'S VISIT PLEASE INDICATE THE PROBLEM THAT BROUGHT YOU TO THE OFFICE

What is your main foot problem today & are there others you would like to discuss? \_\_\_\_\_  
Explain: \_\_\_\_\_  
When did your main problem begin? \_\_\_\_\_ Location of problem area \_\_\_\_\_  
Is the pain:  Burning  Throbbing  Sharp  Dull  Aching  Other? \_\_\_\_\_  
What causes the problem or makes it worse? \_\_\_\_\_  
Was it caused by an injury? Yes \_\_\_ No \_\_\_ (explain if yes) \_\_\_\_\_  
Does anything else affect the problem? Yes \_\_\_ No \_\_\_ (explain if yes) \_\_\_\_\_  
Are there any associated signs or symptoms? Yes \_\_\_ No \_\_\_ (explain if yes) \_\_\_\_\_  
Shoe Size \_\_\_\_\_ Current Weight \_\_\_\_\_ Height \_\_\_\_\_ Do you wear orthotics? \_\_\_\_\_

Do you have Diabetes? Yes \_\_\_ No \_\_\_ If yes, do you take insulin? Yes \_\_\_ No \_\_\_ Number of years \_\_\_\_\_

Have you had any serious illnesses, major injuries, or any major surgeries (if yes explain on back)? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you under a physician's care? Yes \_\_\_ No \_\_\_ If yes, for what condition \_\_\_\_\_

What medications do you take regularly? \_\_\_\_\_

Is there a Family History of any of these disorders:

- Tuberculosis  Epilepsy  Gout  Hypertension  Heart Attack  Kidney disease  Diabetes  
 Allergies  Cancer  Spinal disorder  Mental illness  Arthritis  Migraines  Other \_\_\_\_\_

Immunizations:  Measles  Mumps  Polio  Tetanus  Typhoid  Flu  Pneumonia  TB

**REVIEW OF SYSTEMS (ROS) PLACE AN X IN THE BOXES THAT APPLY TO YOU**

- Do you have:  Arthritis  Joint Disease  Muscle Pain  Stiffness  Bursitis  Lumbago  
 Sciatica  Club foot  Fractures  Sprains  Other \_\_\_\_\_

Gastrointestinal Problems, If yes explain: \_\_\_\_\_

- Do you have:  Poor appetite  Stomach Trouble  Ulcers  Liver trouble  Other explain \_\_\_\_\_

Nervous system Problems, If yes explain: \_\_\_\_\_

- Numbness  Dizziness  Muscle Jerking  Confusion  Stroke  Seizure  Loss of Feeling  Fainting  Convulsion  
 Depression  Weakness  Brain disease  Paralysis  Headaches  Forgetfulness  Spine disease  Other \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_

- Eye Strain  Eye disease  Eye Inflammation  Eye injury  Vision problem  Impaired sight

Cardiovascular/Heart problems, if yes explain: \_\_\_\_\_

- Chest Pain  Heart attach  Rapid heartbeat  Night sweats  Hands swell  Pain over heart  High blood press.  
 Tiredness  Varicose veins  Feet swell  Leg pain on walking  Weakness  Other \_\_\_\_\_

Respiratory problems, if yes explain: \_\_\_\_\_

- Persistent cough  Lung problems  Coughing phlegm  Wheezing  Difficult breathing  Coughing blood  
 Asthma  Bronchitis  Emphysema  Shortness of breath  Hay fever  other \_\_\_\_\_

Skin Rashes and conditions, if yes explain: \_\_\_\_\_

- Itching  Skin rash  Moles  Deformed nails  Eczema  Psoriasis  Abrasions  
 discoloration's  Birth marks  Hives  Bruises  Ulceration's  Skin cancers  Other \_\_\_\_\_

Questions, additional comments and product re-order information: