Patient Information

Date: ________________ MRN#_________________

Name ____ Date of Birth _____________________________
Home Address (street) ___________________________________ Telephone _______________________________
City ______________________ State _______________________Zip code _________________________________

Primary Physician ____

Please check off and list who you were referred by: ____

- ☐ Primary Care Physician
- ☐ Podiatrist
- ☐ Internet
- ☐ Specialist
- ☐ Other

List of Current Medications

1.	**2.**
3.	**4.**
5.	**6.**

What is the nature of your foot or ankle problem? ____

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Medical History

Yes	*No*	*Review of Symptoms*	*Comments and Give Approximate Date*
		Recent weight loss	
		Headaches	
		Trouble with Vision	
		Trouble with Hearing	
		Allergies/Hay fever	
		Asthma	
		Allergic reaction to medication	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/Heart Murmur	
		Circulation	
		High Blood Pressure	
		Chest Pain	

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Yes	*No*	*Review of Symptoms*	
		Lungs (Pneumonia, TB etc.)	
		Shortness of Breath (Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease (or Jaundice)	
		Stomach Trouble	
		Swelling in Feet/Ankles	
		Arthritis	
		Kidney Disease or Stones	
		Gout	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in the Feet or Legs	
		Cramps in the Feet or Legs	
		Low Back Pain	
		Do you Smoke? How much?	
		Do you drink? How Much?	
		Do you take any drugs? (legal or illegal) How much?	
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		Pain in other areas	
		Other Illness or Problems	
		HIV positive	

Operations/Serious Injuries	Approximate Date	Physician	Hospital

Have you previously had physical therapy? When? Where? For what condition? ___________________________

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FOR WOMEN ONLY: Are you Pregnant? ☐ Yes ☐ No

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Is there anything you wish to tell your physician privately? ☐ Yes ☐ No
Is your problem a result of an injury? ☐ Yes ☐ No
Where did it occur? ☐Home ☐ Work ☐ Motor Vehicle Accident ☐ Exercise ☐ Sports ☐ Other
What caused the injury? ☐ Fall ☐ Fighting ☐ Lifting ☐ Twisting ☐ Throwing
☐ Collision/Contact ☐ Pulling/Reaching ☐ Other
Check any of the following that happen at the time of the injury:
☐ Felt Pain ☐ Heard a pop ☐ Swelling ☐ Dislocation ☐ Fracture ☐ Other
Location: ☐ Right foot ☐ Left foot ☐ Right ankle ☐ Left ankle

Have you consulted with an attorney about today's problem? ☐ Yes ☐ No
Are you receiving or have you applied for workers compensation? ☐ Yes ☐ No

Symptoms of Pain Survey

Duration: None (no current symptoms) ☐ Less than one week ☐ 1-3 Weeks ☐
3-6 weeks ☐ 6 wks-3 months ☐ 3-6 months ☐ 6 months-1 year ☐
1-3 years ☐ 3-5 years ☐ more than 5 years ☐
Compared to 3 months ago, how would you rate your symptoms?
Much worse☐ A little worse☐ Same☐ A little better☐ Much better☐
Are you having pain today? Yes ☐ No ☐
Is your pain today: Occasional ☐ Continuous/Constant ☐
On a scale of 0-10 (with 10 being the worst pain imaginable) how would you score your pain today? ________
What time of the day is your pain worse? Morning☐ Afternoon☐ Evening☐ Night time☐
All the time ☐
What makes your pain better? ____
What makes your pain worst? ____

Patient signature ____ Date _______________________
Witness signature____Date_______________________
Physician's signature ____________________________________ Date _______________________

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A.F.A.S. CANCELLATION AND NO SHOW POLICY

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who is waiting for an appointment.

Any appointment cancelled with less than a 24 hour notice or a No Show Visit will be subject to a $25.00 charge. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I, __________________________________ have read and understand the above stated policy

Print Patient Name

Patient signature _________________________________ Date _______________________