Date: ____/____/____

PATIENT NAME:_____ MI___ DOB:___/___/___ AGE:___ SEX M / F

HOME ADDRESS:_____CITYSTATE_____ ZIP:_____

HOME PHONE:_____ CELLPHONE:_____

SOCIAL SECURITY NUMBER:_____

HEIGHT:_____ **WEIGHT**: _____ **SHOE SIZE**:_____

DO YOU HAVE A LEGAL GUARDIAN/ HEALTH CARE POWER OF ATTORNEY? YES / NO
IF YES, NAME:_____ RELATIONSHIP_____

CONTACT NUMBER:_____ ADDRESS_____
CITY:_____ STATE: _____ ZIP_____

EMERCENY CONTACT PERSON NAME:_____ **PHONE**: _____

PRIMARY CARE DOCTOR:_____

WHO MAY WE THANK FOR YOUR REFERAL?._____

PHARMACY:_____**LOCATION**:_____

WHO IS RESPONSIBLE FOR PAYMENT? NAME:_____
ADDRESS:_____ **CITY:** _____ **ZIP**: _____
CONTACT PHONE: _____

INSURANCE INFORMATION:

PRIMARY CARE INSURANCE: _____
ADDRESS:_____ CITY_____ STATE_____ ZIP:_____

NAME OF INSURED:_____ RELATIONSHIP_____
DATE OF BIRTH: _____ EMPLOYEER: _____

SECONDARY INSURANCE INFORMATION:

NAME OF CARRIER:_____

ADDRESS:_____CITY:_____STATE:___ ZIP:_____

NAME OF INSURED:_____RELATIONSHIP_____
DATE OF BIRTH:_____ EMPLOYER:_____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

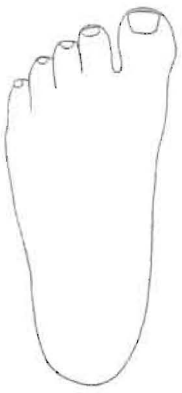
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

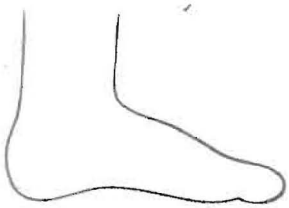
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

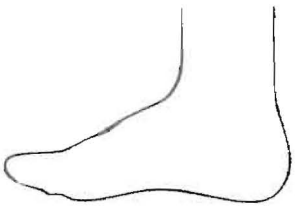


TOP OF FOOT

BOTTOM OF FOOT

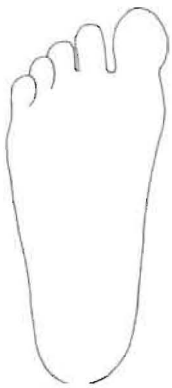


INSIDE OF FOOT

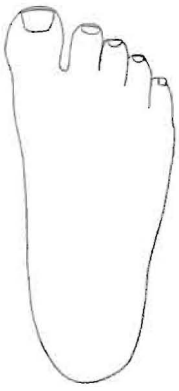


OUTSIDE OF FOOT

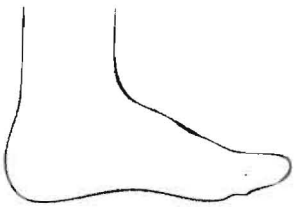
RIGHT FOOT



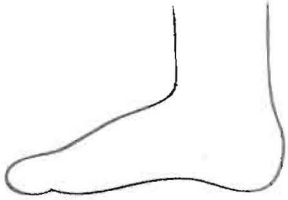
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

1776 YGNACIO VALLEY ROAD, SUITE 102 • WALNUT CREEK, CALIFORNIA 94598

OFFICE (925) 939-3668 or (925) 988-7550 • FAX (925) 944-3338

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

ASSIGNMENT OF INSURANCE BENEFITS

AS A STANDARD PROCEDURE OUR OFFICE WILL BILL ALL INSURANCE COMPANIES AS WELL AS SECONDARY INSURANCE COMPANIES. THERE WILL BE NO CHARGE FOR THIS SERVICE. OUR OFFICE DOES NOT GUARANTEE THAT YOUR INSURANCE COMPANY WILL PAY FOR SERVICES RENDERED. WE WILL MAKE EVERY ATTEMPT TO RECIEVE VERIFICATION OF YOUR POLICY AND WHAT IT COVERS. HOWEVER IF FOR SOME REASON YOUR INSURANCE CLAIM IS DENIED, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.

I HEREBY GIVE PERMISSION TO DR. JONATHAN D. STEINBERG TO ADMINISTER TREATMENT AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF THE CONDITION WHICH BROUGHT ME HERE TODAY.

_____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

1776 YGNACIO VALLEY ROAD, SUITE 102 • WALNUT CREEK, CALIFORNIA 94598
OFFICE (925) 939-3668 or (925) 988-7550 • FAX (925) 944-3338