

Last Name _____ First Name _____ MI _____
Address _____ City _____ Zip _____
Phone (H) _____ (W) _____ Referred by: _____
SS#/MC# _____ Today's Date _____
Date of birth _____ Height _____ Weight _____ Age _____
Employer name/address _____
Health Insurance _____ Subscriber _____
Policy/group #'s _____ / _____
Other health insurance _____
Spouse Name _____ SS# _____
Spouse Employer _____ PH# _____
Family Doctor _____ Last visit _____ PH# _____
Current medications _____
Allergies _____
Medical problems _____
IN CASE OF EMERGENCY NOTIFY: _____

Your foot problems:

Any prior treatment? By whom?

How long have you had your foot complaint?

Does anything help relieve your foot discomfort?

What self treatment, if any, have you done?

Do you have cramps in your calf or thigh when you attempt to walk a certain distance? yes no

List any past surgery and dates:

For what have you been hospitalized?