GADSDEN FOOT CLINIC

Phone: 256-547-1631 Fax: 256-547-1632

PATIENT NAME: LAST _____ FIRST _____ MI _____

DOB ____/____/____ AGE _____ SEX: MALE / FEMALE RACE _____

SSN _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER _____ OCCUPATION _____

SPOUSE'S NAME _____ EMPLOYER _____

DO YOU HAVE A LEGAL GUARDIAN OR POWER OF ATTORNEY? YES / NO

IF YES, NAME _____ RELATIONSHIP _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

IS THERE ANOTHER PERSON WHO YOU AUTHORIZE US TO RELEASE/DISCUSS YOUR MEDICAL INFO WITH? YES / NO

IF YES, NAME _____

PRIMARY CARE DOCTOR _____ PHONE _____

PHARMACY _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ CONTRACT# _____ GROUP# _____

POLICY HOLDER NAME _____ DOB _____ EMPLOYER _____

SECONDARY INSURANCE _____ CONTRACT# _____ GROUP# _____

POLICY HOLDER NAME _____ DOB _____ EMPLOYER _____

- I AM RESPONSIBLE FOR ALL AUTHORIZATIONS OR REFERRALS NEEDED TO SEEK TREATMENT AT THIS OFFICE. I CONSENT TO NECESSARY TREATMENT INCLUDING DRUGS, X-RAYS AND OTHER STUDIES THAT MAY BE USED BY THE PHYSICIAN OR STAFF. I UNDERSTAND THAT GADSDEN FOOT CLINIC DOES NOT DO PRIOR AUTHORIZATIONS FOR MEDICATIONS.
- I UNDERSTAND THAT GADSDEN FOOT CLINIC HAS A PRIOR AGREEMENT WITH MY INSURANCE COMPANY. THAT GADSDEN FOOT CLINIC WILL BILL MY PLAN AND ONLY REQUIRE ME TO PAY CO-PAY/CO-INSURANCE/DEDUCTIBLE AT THE TIME OF SERVICE. GADSDEN FOOT CLINIC ACCEPTS VISA, MASTERCARD, AMERICAN EXPRESS, CASH OR CHECK.
- IF GADSDEN FOOT CLINIC DOES NOT HAVE A PRIOR AGREEMENT WITH MY INSURANCE COMPANY, I UNDERSTAND THAT ALL CHARGES FOR MY CARE ARE DUE AT THE TIME OF SERVICE AND MY INSURER WILL THEN SEND PAYMENT TO ME.
- IN THE EVENT THAT A SERVICE RENDERED IS NOT COVERED OR I DON'T HAVE AUTHORIZATION, I WILL BE RESPONSIBLE FOR THE COMPLETE CHARGE AT TIME OF SERVICE. I HEREBY GUARANTEE THE PAYMENT OF ALL ACCOUNTS FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I ALSO UNDERSTAND THAT IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I AM RESPONSIBLE FOR ALL CHARGES.
- I UNDERSTAND THAT THERE IS A $30 SERVICE FEE FOR ANY RETURNED CHECK
- I UNDERSTAND THAT THERE IS A $25 SERVICE FEE FOR ANY INSURANCE FORMS NEEDING TO BE COMPLETED BY THE PHYSICIAN AND WILL BE DUE PRIOR TO BEING STARTED.

_____ _____

SIGNATURE OR PATIENT OR LEGAL GUARDIAN DATE

PATIENT NAME: _____

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL
- ☐ FATIGUE
- ☐ FEVER
- ☐ WEIGHT CHANGE

SKIN
- ☐ ITCHING
- ☐ DRYNESS
- ☐ NAIL CHANGES
- ☐ RASH

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ COLD EXTREMITIES

ENDOCRINE
- ☐ INCREASED THIRST
- ☐ SWEATS
- ☐ COLD/HEAT INTOLERANCE

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ BACK PROBLEMS
- ☐ JOINT STIFFNESS
- ☐ MUSCLE WEAKNESS

EYES
- ☐ BLURRY VISION
- ☐ CATARACTS
- ☐ GLASSES/CONTACTS

PSYCHIATRIC
- ☐ DEPRESSION
- ☐ DISORIENTATION
- ☐ MEMORY LOSS

URINARY
- ☐ FREQUENCY
- ☐ PAIN WHILE URINATING

GASTROINTESTINAL
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ HEARTBURN
- ☐ NAUSEA/VOMITING

RESPIRATORY
- ☐ ASTHMA
- ☐ WHEEZING
- ☐ SHORT OF BREATH

NEUROLOGICAL
- ☐ BURNING
- ☐ NUMBNESS
- ☐ TINGLING

PREVIOUS SURGERIES - PLEASE CHECK ALL THAT APPLY

- ☐ BREAST REDUCTION
- ☐ GASTRIC BANDING
- ☐ HIP SURGERY
- ☐ HEART STINT
- ☐ THYROIDECTOMY
- ☐ APPENDECTOMY
- ☐ JOINT REPLACEMENT _____
- ☐ CHOLECYSTECTOMY
- ☐ KNEE ARTHROSCOPY
- ☐ HYSTERECTOMY
- ☐ BACK/NECK SURGERY
- ☐ TONSILLECTOMY
- ☐ SHOULDER SURGERY
- ☐ C-SECTION
- ☐ KNEE SURGERY
- ☐ PACEMAKER
- ☐ CARPAL TUNNEL
- ☐ TUBAL LIGATION
- ☐ COLECTOMY
- ☐ OTHER _____
- ☐ HERNIA
- ☐ MASTECTOMY
- ☐ VASECTOMY
- ☐ SINUSECTOMY
- ☐ CATARACT
- ☐ PVD PROCEDURE

SOCIAL HISTORY

TOBACCO USE (CIRCLE ONE) NEVER YES FORMER USER

IF CURRENT USER, WHAT TYPE OF TOBACCO AND HOW OFTEN? _____

IF FORMER USER, WHAT TYPE OF TOBACCO AND HOW OFTEN? _____

ALCOHOL USE (CIRCLE ONE) NEVER OCCASIONAL MODERATE DAILY

IF YES, WHAT TYPE? (CIRCLE ONE) BEER WINE LIQUOR

FAMILY HISTORY : ANY RELATIVES WITH ANY OF THE FOLLOWING? (CHECK BOX)

	MOTHER	FATHER	BROTHER	SISTER
DIABETES	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐
RHEUMATOID ARTHRITIS	☐	☐	☐	☐
FOOT PROBLEMS	☐	☐	☐	☐

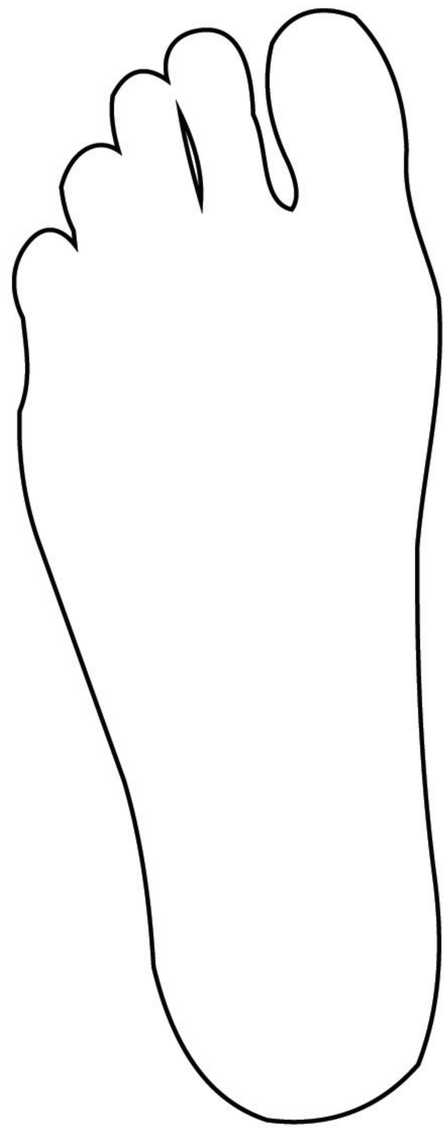
PAST MEDICAL HISTORY: CHECK ANY THAT APPLY.

- ☐ ANEMIA
- ☐ MIGRAINE
- ☐ EPILEPSY
- ☐ GOUT
- ☐ HIV
- ☐ ARTIFICIAL JOINT
- ☐ ULCER (GASTRIC)
- ☐ ANXIETY
- ☐ COPD
- ☐ OSTEOPOROSIS
- ☐ ACID REFLUX
- ☐ DEMENTIA
- ☐ DIVERTICULITIS
- ☐ ARTHRITIS
- ☐ HEART ATTACK
- ☐ FIBROMYALGIA
- ☐ NEUROPATHY
- ☐ BACK PROBLEM
- ☐ DEPRESSION
- ☐ OTHER: _____
- ☐ CORONARY ARTERY DISEASE
- ☐ CONGESTIVE HEART FAILURE
- ☐ ENLARGED PROSTATE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ MULTIPLE SCLEROSIS
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ THYROID DISEASE
- ☐ SEASONAL ALLERGIES
- ☐ HERNIA
- ☐ DIABETES
- ☐ CANCER
- ☐ STROKE
- ☐ GLUCOMA
- ☐ HEPATITUS
- ☐ CATARACT
- ☐ BLOOD CLOT
- ☐ ASTHMA

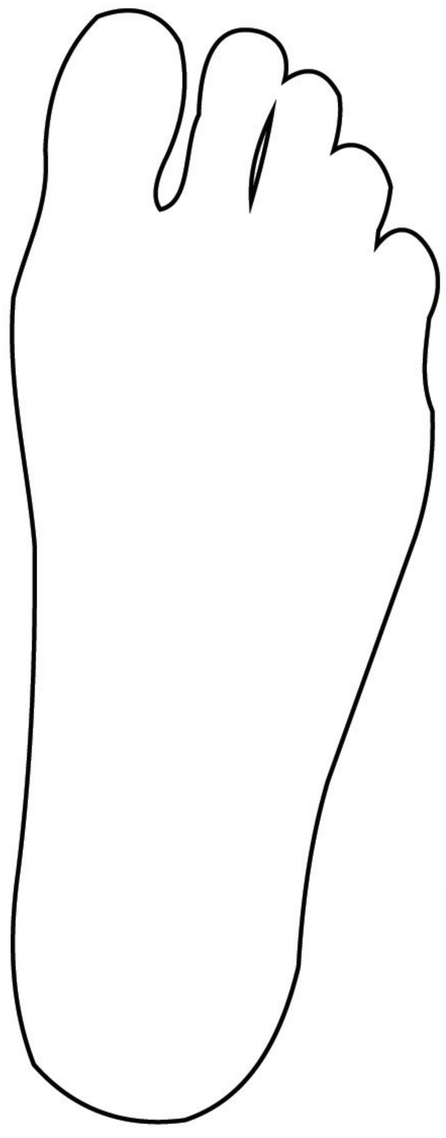
PATIENT NAME: _____

WHAT SPECIFIC PROBLEM BRINGS YOU IN TODAY? _____

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



LEFT FOOT



RIGHT FOOT

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

DID YOUR PAIN/PROBLEM ☐ BEGIN ALL OF THE SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ STABBING ☐ ITCHING

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0-10? PLEASE CIRCLE.

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

SINCE YOUR PAIN STARTED, HAS IT: ☐ STAYED THE SAME ☐ GOTTEN WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM WORSE?

☐ WALKING
☐ STANDING
☐ DAILY ACTIVITIES
☐ RESTING
☐ DRESS SHOES
☐ CLOSED TOE SHOES
☐ FLAT SHOES
☐ RUNNING
☐ OTHER: _____

WHAT MAKES YOUR PAIN/PROBLEM BETTER? _____

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

IF YES, WAS IT WORK RELATED? ☐ NO ☐ YES

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

DO YOU EXERCISE? ☐ NEVER ☐ OCCASIONALLY ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPE OF EXERCISE: _____

PATIENT NAME: _____

PATIENT HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. DRUGS INCLUDE PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, HERBAL PRODUCTS, NUTRITIONAL SUPPLEMENTS AND RECREATIONAL DRUGS.

DRUG	DRUG STRENGTH	AMOUNT AND TIMES TAKEN DAILY

ALLERGY LIST: DO YOU HAVE ANY DRUG ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

_____

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.

_____

PRINT NAME OF PATIENT

_____

SIGNATURE OF DOCTOR

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

DATE

_____

DATE