



WELCOME TO OUR OFFICE

Date: _____

Patient's Name: _____

Social Security #: _____

Address: _____
Street City State Zip

Home Phone: _____

Business Phone: _____

Date of Birth: _____

Marital Status: _____

Occupation: _____

Employer: _____

Email Address: _____

Guardian's Name (If patient is a minor): _____

Address (If different from patients): _____

Person to contact in case of emergency: _____

Address: _____

How did you hear about us? _____

What type of work do you do? _____

Please answer the following questions to the best of your ability:

Your: Height: _____ Weight: _____ Shoe Size: _____

Physician's Name and Address: _____

_____ Date last seen: _____

What medications are you taking now Prescription and Non-Prescription:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list past surgeries or hospitalizations with dates:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke (amount): _____ /How long? _____ Alcohol (amount): _____

() I am not allergic to anything to my knowledge

() I am allergic to (Please Check)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Codeine	<input type="checkbox"/> Iodine X-ray
<input type="checkbox"/> Demerol	<input type="checkbox"/> Adhesives/Tape	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Antihistamines/NSAIDS	<input type="checkbox"/> Other _____		

() I have, or have had the following:

<input type="checkbox"/> Heart Valve Condition	<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Tumors
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Carpal tunnel
<input type="checkbox"/> Cardiac stent	<input type="checkbox"/> Rheumatism/Arthritis	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> GERDS	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Diabetes-How Long? _____	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Other _____

() I have, or have had the following:

<input type="checkbox"/> Back Problems? _____			
<input type="checkbox"/> Hip Conditions? _____			
<input type="checkbox"/> Knee Conditions? _____			
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Migraines	<input type="checkbox"/> Broken bone _____

() I am currently experiencing, or suffering from:

<input type="checkbox"/> Flat feet	<input type="checkbox"/> Pain in feet getting out of bed
<input type="checkbox"/> Poor coordination	<input type="checkbox"/> "Toe-in" or "Toe-out" gait
<input type="checkbox"/> Heel or arch pain	<input type="checkbox"/> Leg pain (shin splints)
<input type="checkbox"/> Pain or fatigue of feet or legs in activity	<input type="checkbox"/> Ankle instability (easy twisting injuries)
<input type="checkbox"/> Achilles tendon pain	<input type="checkbox"/> Difficulty/pain with brisk walking or running
<input type="checkbox"/> Discoloration of toes/foot	<input type="checkbox"/> Pain legs occurs at the same distance every time
<input type="checkbox"/> Ankle swelling or stiffness	<input type="checkbox"/> Coldness in the legs or feet that is uncomfortable
<input type="checkbox"/> Pain in the feet or legs without exercise	<input type="checkbox"/> Non/poor healing sore on the leg or foot
<input type="checkbox"/> Foot/toes/legs burn	<input type="checkbox"/> Feet/toes feel numb

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

<u>Tingling / Numbness in:</u>	<u>Pain radiating into:</u>	<u>Weakness of the:</u>	<u>Difficulty with:</u>
<input type="checkbox"/> Legs R / L	<input type="checkbox"/> Ankles R / L	<input type="checkbox"/> Legs R / L	<input type="checkbox"/> Standing
<input type="checkbox"/> Ankles R / L	<input type="checkbox"/> Feet R / L	<input type="checkbox"/> Ankles R / L	<input type="checkbox"/> Walking
<input type="checkbox"/> Feet R / L	<input type="checkbox"/> Toes R / L	<input type="checkbox"/> Feet R / L	<input type="checkbox"/> Sitting
<input type="checkbox"/> Bending			
<input type="checkbox"/> Lifting			
<input type="checkbox"/> Kneeling			

() *Do you have any immediate family members who are diabetic, have high blood pressure, or have problems with their feet, knees, hips, or back? If so, who?* _____

I hereby give permission to Dr. Don Crank to release any information requested by my insurance company. I also give the doctor permission to perform such general procedures, as they may deem necessary in the diagnosis and/or treatment of my foot condition.

Date

Signature of patient

Parent or guardian (if patient is a minor)

Patient's Name: _____

Date: _____

What is your current foot problem? _____

How long have you had this condition? _____

What makes it worse/when does it hurt/bother you the MOST? _____

What makes the condition better/when does it bother you the LEAST? _____

How have you tried to treat this problem yourself? _____

Have you been treated or seen for this condition by another doctor and what were the treatments or suggestions?

What other foot/ankle problems have you had in the past? _____
