

**PLEASE FILL OUT AND READ COMPLETELY**

Dr. Young

Dr. Kaur

Today's Date

Last First MI Sex: M F

Patient SS# Date of Birth

Marital Status: S M D W Race: Hispanic/Latino White/Caucasian

Black Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander Other

Phone Work Cell Email

Mailing Address

City State Zip Code

Name and **RELATIONSHIP** of Emergency Contact

**PHONE** of Emergency Contact

Name of Primary Care Physician Date Last Seen

Phone Fax

How did you hear about us? If referred, from whom?

**PERSON RESPONSIBLE FOR SERVICES IF DIFFERENT THAN LISTED ABOVE**

Name SS# Phone DOB

Address (if different from above)

City State Zip Code

**SIGNATURE OF RESPONSIBLE PARTY**

**DATE**

**I AM AWARE THAT IF CARSON VALLEY FOOT CARE IS CONTRACTED WITH MY INSURANCE, IT DOES NOT NECESSARILY MEAN MY INSURANCE WILL COVER MY VISIT. I UNDERSTAND THAT CARSON VALLEY FOOT CARE DOES NOT HAVE ACCESS TO MY INSURANCE POLICY, AND THEREFORE I NEED TO BE AWARE OF MY COVERAGE, AND IF I AM NOT AWARE OF MY COVERAGE I WILL INFORM THE OFFICE SO THAT THEY CAN ASSIST ME IN UNDERSTANDING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY OUTSTANDING BALANCES THAT MY INSURANCE DOES NOT PAY. CARSON VALLEY FOOT CARE IS HERE TO ASSIST YOU IN EVERY POSSIBLE WAY OF UNDERSTANDING YOUR COVERAGE WITH THIS OFFICE.**

**SIGNATURE**

**DATE**

**Please describe what brings you to the office today:**

**Location of pain/primary complaint:** Ankle Achilles Tendon Midfoot Arch Forefoot  
Heel Sole of Foot Ball of Foot Top of Foot Big Toe Lesser Toes Toenails

**How long has your problem been present?** 1-3 Days 3-7 Days 1-3 Weeks 3-6 Weeks  
6-8 Weeks 3-6 Months 6-9 Months 9-12 Months Greater than 1 Year

**Onset of condition or injury:** Gradual onset over time Sudden onset from activity or injury

**Course/progression of condition:** Severe Worsening Moderate Worsening Mild Worsening  
Steady/Unchanging Mild Improvement Moderate Improvement Considerable/Good Improvement

**Pain/condition aggravated by:** Any Weight Bearing Standing Walking Running Exercise  
Bending Stooping Pressure to Ball of Foot Pressure from Shoes Pressure from Jumping

**Have you attempted any treatments to relieve your problem?**

Rest Ice Elevation Change Shoe Gear Over the Counter Padding  
Over the Counter Anti-inflammatory Medication (Motrin, Aleve, Tylenol, Aspirin, etc)

**How much improvement and relief have you achieved with previous treatments?** Mild Improvement  
Moderate Improvement Considerable Improvement No Improvement Worsening of Condition

**What is your activity level at work?**

Sitting Standing Walking Considerable Movement/Walking Retired

What is your height?

What is your weight?

What is your shoe size?

**Please answer YES or NO to the following:****Do/did you have:**

Diabetes	Yes	No
Thyroid Disease	Yes	No

**Cardiovascular:**

Hypertension/high blood pressure	Yes	No
Heart Attack	Yes	No
Pacemaker	Yes	No
Congestive Heart Failure	Yes	No
Other		

**Vascular/Circulation:**

Blocked Arteries	Yes	No
High Cholesterol	Yes	No
Blood Clot	Yes	No
Stroke/CVA	Yes	No
Other		

**Gastrointestinal:**

Ulcer	Yes	No
Liver Disorder	Yes	No
Hepatitis A/B/C	Yes	No
Other		

**Hematological:**

Anemia	Yes	No
Sickle Cell Disease or Trait	Yes	No
Blood Transfusion	Yes	No
Other		

**Neurological:**

Seizures	Yes	No
Tremor	Yes	No
Polio	Yes	No
Other		

**Musculoskeletal:**

Arthritis/Rheumatoid	Yes	No
Gout	Yes	No
Other		

**Immunology:**

HIV/AIDS	Yes	No
Frequent Infections or Weak Immune System	Yes	No
Other		

**Have you ever been anticoagulated with any of the following blood thinners?**

Coumadin	Yes	No
Heparin	Yes	No
Plavix	Yes	No
Other		

**Have you had any type of cancer?** Yes No  
Specify

**Have you had any joint replacements?**

Type:  
Date of Replacement:

**Have you had any surgeries?** Yes No  
Type/Date of Surgeries:

**Complications with Surgery?** Yes No  
Specify:

**Please answer YES or NO to the following:**

**Have you ever had:**

Measles	Yes	No
Mumps	Yes	No
Rheumatic Fever	Yes	No
Chicken Pox	Yes	No
Pneumonia	Yes	No
Covid-19	Yes	No

**Childhood Immunizations:**

Measles	Yes	No
Mumps	Yes	No
Rubella	Yes	No
Diphtheria	Yes	No
Tetanus	Yes	No
Chicken Pox	Yes	No
Polio	Yes	No
Tuberculosis	Yes	No
Pneumonia	Yes	No
Flu	Yes	No
Covid-19	Yes	No

**Family History (Cancer, Diabetes, etc):**

**Do You:**

Drink Alcohol	Yes	No
How often?		
Use Hallucinogenic Drugs:	Yes	No
How often?		

**Do you smoke?**

Yes      No

How often?

Have you ever smoked?

Yes      No

Year quit:

If so, how long did you smoke?

**Medication Allergies:**

**Food Allergies:**

**Plant Allergies:**

**Medications Currently Taking (including aspirin):**

**PLEASE READ AND FILL OUT THIS FORM:**

**PRINT and bring to your first appointment**

**or**

**EMAIL to**

**[CARSONVALLEYFOOTCARE@YAHOO.COM](mailto:CARSONVALLEYFOOTCARE@YAHOO.COM)**