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 sgggrg 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

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