PLEASE FILL OUT AND READ COMPLETELY

Dr. Young 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_____
Mailing Address_____
City_____State_____Zip_____
E-mail_____

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 than above)_____
City_____State_____Zip_____

_____ _____
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.

SIGNED_____**DATE**_____

NEXT PAGE →

Please describe what brings you to the office today?

_____

How would you describe your pain?

Sharp aching throbbing Shooting electrical sensation pins and needles burning

Location of pain or primary complaint:

Ankle Achilles tendon heel midfoot arch forefoot

Sole of foot ball of foot top of foot big toe lesser toes toenails

How long has your problems 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)

In home whirlpool stretching trimming out toenail yourself applying skin cream

Applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, ext)

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:_____

NEXT PAGE →

Please answer yes/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/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_____
_____

Have you ever had:

Measles Yes[] No[]
Mumps Yes[] No[]
Rheumatic Fever Yes[] No[]
Chicken Pox Yes[] No[]
Pneumonia Yes[] No[]

Childhood Immunizations:

Measles Yes[] No[]
Mumps Yes[] No[]
Rubella Yes[] No[]
Dipheria Yes[] No[]
Tetanus Yes[] No[]
Chicken Pox Yes[] No[]
Polio Yes[] No[]
Tuberculosis Yes[] No[]
Pneumonia Yes[] No[]
Flu Yes[] No[]

Family History:(Cancer, Diabetes, ETC.)

NEXT PAGE →

_____
_____
_____

Do you:
Drink Alcohol Yes[] No[]
How often?_____
Use hallucinogenic drugs Yes[] No[]
Specify:_____

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):
_____
_____
_____
_____

NEXT PAGE →