

PATIENT INFORMATION

PATIENT: _____ DATE: _____/_____/_____

1.) CHIEF COMPLAINT: _____

2.) DURATION: _____ WHICH FOOT?: _____ RIGHT _____ LEFT _____ BOTH

3.) IS THE CHIEF COMPLAINT A RESULT OF AN INJURY?: YES _____ NO _____

DATE OF INJURY?: _____

4.) WHAT IS YOUR TREATMENT GOAL?: () DIAGNOSIS () PAIN REDUCTION ONLY

() CORRECTION () OTHER

5.) DATE OF LAST PHYSICAL?: _____ DO YOU SMOKE?: _____

MEDICAL HISTORY (Please Indicate With An "X")

<input type="checkbox"/> Allergies*	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Raynaud's Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Bleeding	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Broken Bones(s)	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Tumors
<input type="checkbox"/> Circulation Trouble	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Diabetes**	<input type="checkbox"/> Liver Trouble	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Phlebitis	

*LIST ALLERGIES: _____

ALLERGIC TO:

<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Drugs	Other: _____
<input type="checkbox"/> Novocaine	<input type="checkbox"/> Foods	_____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Materials	_____

HOSPITALIZATIONS?: (List Dates and Reasons) _____

OPERATIONS?: (List Dates and Reasons) _____

WHAT MEDICATIONS DO YOU TAKE?: _____

OTHER MEDICAL HISTORY?: _____