Northwest Footcare, LLC

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How did you first hear about us?
[ ] Internet [ ] friendly referral [ ] Dr. referral, whom_____ [ ] Other

Contact Information

Patient Name_____ Date of Birth_____ [ ] M [ ] F

Preferred Name_____

Email _____

Home address_____

City_____State_____Zip_____

Mailing address_____

Home Phone_____ Work Phone_____

Social Security #_____Occupation_____

Employers Name and Address_____

Primary Insurance_____ Secondary Insurance_____

Person responsible for this bill (If different than above)

Name _____Date of Birth_____

Mailing address_____

City_____State_____Zip_____

Home Phone_____ Work Phone_____

Social Security #_____Relationship_____

Agreement and Consent

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to Northwest Footcare, LLC for professional services rendered. I understand that Northwest Footcare, LLC will bill my insurance as a courtesy, but I am responsible for any balance not covered by my insurance.

I acknowledge that both the Financial Policy and Notice of Privacy Practices from Northwest Footcare, LLC have been made accessible to me and I agree to the terms.

I give permission to the physicians at Northwest Footcare, LLC to administer treatment and to perform such procedures as maybe deemed necessary or advisable in the diagnosis and/or treatment of the foot and related conditions after I have consented. By Oregon law, I am entitled to know the procedure, alternatives and risks involved, with a detailed explanation if so desired.

I understand that undesirable outcomes MAY OCCUR with procedures and adverse side effects or reactions MAY OCCUR with medications. I will be responsible for following the doctor's instruction and that my non-compliance may result in a poor outcome and may be grounds for termination of the doctor/patient relationship. I will also be responsible for continuing any recommended follow up care and for any poor outcome which may result from the lack of doctor recommended follow up care.

_____

Signature of Patient or Responsible Party Date

Health History

Northwest Footcare, LLC

Patient Name_____Age_____Height_____Weight_____Shoe Size_____

Primary Care Physician_____Date last seen_____Referring source_____

Reason for visit_____

Describe **when**, **where** and **how** the problem started_____

_____

_____

Describe in detail the **type of pain or sensation** you are having_____
(none, tender, sharp, dull ache, burning, tingling, radiating, shooting, stabbing, throbbing, localized, constant, intermittent, unpredictable, related to?)

_____Have youever had this before?_____

What makes it better or worse?_____

What has been the progression — getting worse, getting better, the same?_____

Rate the pain now (0= none, 10= worst imaginable) and previous range_____
(ex: 5, 3 in morning and 8 by bedtime...or 8 when injured last week and now has faded to 2-3)

Was it related to an **accident**?_____ Work related injury (**workers comp**)?_____ Did you report it?_____

How has this affected your **quality of life**, preventing you from doing the activities that you enjoy?_____
(ex: limits walking, exercise; can't wear certain shoes; nagging pain; affects mood, relationships, my job; unpleasant appearance/odor)

_____

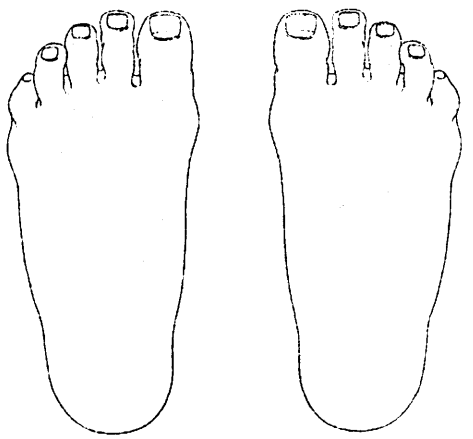
Describe any **previous treatment** by a professional_____by whom_____

Personal treatment_____
(i.e. nothing, researched the internet, asked others, over-the counter products, shoes, orthotics or special shoe inserts, ice/heat, stretching, soaking, tape, pads, dressing change, other specialists seen, any x-rays or lab tests performed, what has or has not helped, etc)

What do you think might be the cause?_____

What are your specific goals of this appointment?_____
(diagnosis, 2nd opinion, recommendations for self care, information resources, treatment, whatever it takes-be aggressive, surgery, referral)

Please mark the area involved:



Allergies and reaction:_____
(penicillin, sulfa, codeine, iodine, tape, local anesthetics, other)

Current **Medications/dose** (or supply list):_____

_____

_____

_____

Surgeries and year performed:_____

_____

_____

Social History

Do you smoke? Y N How many packs/day?_____ Did you smoke in past? Y N Stopped how long ago?_____

Do you drink alcohol? Y N How much and how often_____

Illicit drug use? Y N Please specify_____ Are you on narcotic pain contract? Y N

What is your occupation?_____Does it involve mostly standing or sitting?_____

Do you exercise regularly? Y N What exercise or activities do you enjoy?_____

Family History (Please specify if your parents or siblings had any of the following health conditions):

__Diabetes __Heart Disease __Hypertension __Stroke __Cancer __Gout __Rheumatoid Arthritis __Bunions

__Toe deformity __Ingrown toenails __High arch __Flat feet __Warts Other_____

Past Medical History (Please check if you had any of these): none

My General Health is: excellent/ good/ fair/ poor

__Alzheimers/ significant memory loss
__Arthritis
__Autoimmune Disease
__Bleeding or clotting disorders
__Breathing/Lung problems/TB
__Cancer_____
__Cellulitis/infections
__Congestive Heart Failure
__Deep Vein Thrombosis/Pulmonary Embolism
__Depression/Anxiety/Bipolar
__Diabetes. How many years_____
How well controlled? A1C_____
__Fractures_____
__GI Reflux/ulcers/bleed
__Gout
__Hepatitis
__HIV/AIDS
__Infections/cellulitis/fungal/MRSA
__Heart Disease/MI/coronary/valvular/murmur
__High Blood Pressure
__High Cholesterol
__Hypertrophic thick scar formation
__Joint replacement/hip/knee/foot
__Kidney Disease/Dialysis
__Liver disease
__Mechanical heart valve//coronary/carotid stent
__Neuropathy
__Organ transplant
__Osteoporosis
__Parkinsons
__Peripheral Arterial Disease/Poor Circulation
__Psoriasis/other skin disorder_____
__Sciatica/lower back problems
__Seizures
__Stroke/TIA's/embolism
__Thyroid problems/hyper/hypo
__Varicose veins
__Warts
Other:

Review of Systems: (Please check if you **currently** have):

General
__fever or chills
__nausea, vomiting, diarrhea

Hematologic
__anemia
__use of blood thinners

Eyes, Ear, Nose, Throat, Mouth
__headaches
__visual disturbance/cataracs/glaucoma/poor vision
__hearing loss/dizziness/ringing in ears
__sore throat

Cardiovascular
__leg or chest pain that limits walking
__poor circulation
__leg swelling
__heart palpitations/murmur/rapid or slow pulse

Respiratory
__difficulty breathing/shortness of breath/cough/wheezing

Gastrointestinal
__blood in stool/ulcers
__constipation

Genitourinary
__currently pregnant
__excessive urination

Integumentary (skin)
__athletes foot/ thick, yellow toenails
__dry, scaly skin/itching
__lower leg/foot ulcers
__rash __warts

Psychiatric
__sleep disorders/apnea

Immunologic
__swollen lymph nodes

Neurological
__numbness or tingling in feet
__weakness, poor balance or walking impairment
__spasm with color changes in toes or fingers

Endocrine
__unexplained fatigue/ weight gain/weight loss
__cold intolerance

Musculoskeletal
__back pain __joint pain/stiffness/swelling __arthritis
__leg/foot cramps __leg/foot weakness

Patient Name:_____