Practice: MARC B KLEIN DPM PA **Appointment Date** ____ / ___ / ___

Patient Name: _____ DOB: ___ / ___ / ___ Chart Number: _____ Office Use Only

Sex: ◯ M ◯ F Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced SS#: _____

Email: _____ Spouse/Partner Name: _____
(Email newsletter, reminder, statement, etc.)

Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Cell #: _____ Other#: _____
Example: (555) 123-4567 Example: (555) 123-4567 Example: (555) 123-4567

Employer Name: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? ◯ Yes ◯ No

Insured Information

Subscriber Name: _____ Relationship to insured: ◯ Spouse ◯ Child ◯ Self ◯ Other

Phone #: _____ Insured Sex: ◯ Male ◯ Female DOB: ___ / ___ / ___
Example: (555) 123-4567

Address: _____ City: _____ State: _____ Zip: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ◯ Yes ◯ No

Important: Be prepared to present your insurance cards at your initial visit.

How did you find out about our practice? ◯ Physician ◯ Internet ◯ Family Member ◯ Friend
◯ Other: _____

Whom can we thank for this referral? Name: _____

What is the reason for your visit today?

Result of accident or work injury? ◯ Yes ◯ No

How long has this bothered you? [1,2,3,4,5,6,7] Enter number: ___ Days ___ Weeks ___ Months ___ Years

What treatments have you tried and have they been effective? Please explain:

On scale of 1-10 (1 being no pain & 10 being the worst) what is your level of pain? ___ /10

The pain quality is: ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date ___ / ___ / ___

Practice: MARC B KLEIN DPM PA **Today's date____/ ___ /____**

Name:_____ **Chart#:** _____ **Date of Birth:**_____/____ /____
Office Use Only

Ethnicity: ◯Hispanic or Latino ◯Not Hispanic or Latino ◯I decline to specify

Race: ◯Asian ◯American Indian or Alaska Native ◯Black or African American
◯White ◯Native Hawaiian or other Pacific Islander
◯I decline to specify ◯I do not know

Preferred Language: _____ ☐I decline to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____
Example: (555) 123-4567

Pharmacy Address:_____City _____ State ____ Zip _____

Primary Care Physician:_____ **Phone:** _____ **Date Last Seen:** ____/ ___ / ___

Address: _____City _____ State ____ Zip _____

Referring Physician:_____ **Phone:** _____ **Date Last Seen:** ____/ ___ / ___

Address: _____City _____ State ____ Zip _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ◯Yes ◯No Can we send mail to the address on file? ◯Yes ◯No

Can we call the phone number on file? ◯Yes ◯No Can we leave voicemail on machine: ◯Yes ◯No

Will you allow us to send Internet based (e-mail) delivery of reminders and newsletters? ◯Yes ◯No

If Yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

◯Current, every day ◯Smoker, current status unknown
◯Current, some days ◯Heavy Tobacco ◯Unknown if ever
◯Former ◯Never ◯Light Tobacco ◯I decline to answer

Vital Signs

Shoe Size: _____
Blood Pressure: _____ / _____
Height:_____ Weight: _____

Current Medications

◯No Medications ◯I take the following Medications:

Name:_____Dose: _____
Name:_____Dose: _____
Name:_____Dose: _____
Name:_____Dose: _____
Name:_____Dose: _____
Name:_____Dose: _____
Name:_____Dose: _____

Drug Allergies

◯No Known Drug Allergies ◯I have the following Drug Allergies:

Name: _____Reaction:_____
Name: _____Reaction:_____
Name: _____Reaction:_____
Name: _____Reaction:_____
Name: _____Reaction:_____
Name: _____Reaction:_____
Name: _____Reaction:_____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ◯Yes ◯No

Have you fallen in the last 12 months? ◯Yes ◯No **If Yes, were you injured from the fall?** ◯Yes ◯No

Advanced Directives: ◯Living Will ◯DNR ◯Durable Power of Attorney ◯Surrogate Appointed ◯None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. **(Assignment of Benefits):** I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. **(HIPPA Privacy):** I acknowledge that I received my HIPPAA Privacy Practices Notice. **(Medication History):** I authorize the Doctor's office to retrieve my medication history.

Patient Signature:_____ Date _____ /_____ / ____

History and Physical

Name _____ **DOB** ____ / ____ / ____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood Disorders ☐ Circulation Problems ☐ Musculoskeletal ☐ Breathing Issues
☐ Liver ☐ Sleep Apnea ☐ Gout ☐ Allergies ☐ Heart Disease ☐ Asthma
☐ Heart Murmur ☐ Stomach/Bowel ☐ Depression ☐ Anxiety Disorder ☐ Mental Illness ☐ Kidney Disease
☐ Blood Clot ☐ High Cholesterol ☐ High Blood Pressure ☐ Cancer ☐ Hepatitis
Neuropathy *(specify)* _____ Thyroid *(specify)* _____ ☐ Diabetes: ☐ Type 1 ☐ Type 2
Arthritis *(specify)* _____ Other *(specify)* _____ ☐ HIV ☐ CVA
Are your pregnant? ◯ Yes ◯ No **Are you nursing?** ◯ Yes ◯ No ☐ Skin Disorders ☐ Stroke

Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ◯ Yes ◯ No
If Yes, please describe _____
Do you have artificial joints? ◯ Yes (where? _____) ◯ No Do you have an artificial heart valve? ◯ Yes ◯ No

Social History
Do you drink alcohol? ◯ Yes, everyday (5-7 days/week) ◯ Yes, occasionally/socially ◯ No/Rarely
What is your occupation? _____ Does it involve mostly ◯ standing ◯ sitting
Do you exercise regularly? ◯ No, I do not exercise regularly ◯ Yes, I do the following regular exercise _____

Family History Is there any family history *(blood relative)* of: *(Please specify family member)*

Alzheimer's	_____	Depression	_____
Arthritis	_____	Diabetes	_____
Bleeding Disorders	_____	Emphysema	_____
Blood Clot	_____	Heart Disease	_____
Cancer	_____	High Blood Pressure	_____
Cataracts	_____	Neurological	_____
Circulation Problems	_____	Strokes	_____

Other (specify):_____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers ☐ constipation
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica ☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis	☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature _____ Date ____ / ____ / ____

Patient Name: _____ **Date: ____ /____ / ___**

Please provide as much information as possible.

FEET:

Do you have any **FOOT** pain? ◯ Yes ◯ No ☐ Left ☐ Right

If yes, please explain:

How long has this been going on? _____

Previous treatment for this pain/problem _____

Does anything make it better? _____

Does anything make it worse? _____

KNEE OR HIP:

Do you have **KNEE or HIP** pain? ◯ Yes ◯ No ☐ Left ☐ Right

If yes, please explain:

How long has this been going on? _____

Previous treatment for this pain/problem _____

Does anything make it better? _____

Does anything make it worse? _____

BACK

Do you have any **BACK** pain? ◯ Yes ◯ No ☐ Left ☐ Right

If yes, please explain:

How long has this been going on? _____

Previous treatment for this pain/problem _____

Does anything make it better? _____

Does anything make it worse? _____

ORTHOTICS (Arch Support)

Do you currently wear **Orthotics (arch supports)**? ◯ Yes ◯ No

If Yes, were they custom molded? ◯ Yes ◯ No

If yes, were they over the counter style, bought from a store? ◯ Yes ◯ No

If yes, did they help at all? ◯ Yes ◯ No

Do they still help? ◯ Yes ◯ No

SHOE GEAR:

What type of **shoe gear** do you wear and how often?

_____ % of Time Sneakers/Running/Tennis
_____ % of Time Casual shoes, flats
_____ % of Time Pumps of low heels (Women)
_____ % of Time High Heels 2" or greater (Women)
_____ % of Time Work boots
_____ % of Time Flip Flops
_____ % of Time Lace up dress shoes (Men)
_____ % of Time Loafers/Deck shoes (Men)

When you are at home do you wear:

☐ Bare Feet ☐ Slippers ☐ Regular shoes ☐ Other _____

In the last few months, has there been a recent change in:

Weight ◯ Yes ◯ No If yes: ◯ Up ◯ Down ☐ Work ☐ Activity ☐ Shoe gear

Please explain:

This is the most important part of the paperwork.

Please tell me: What are your goals and expectations relating to your problem?:

Relating to your specific complaint(s), what would you really like to accomplish during your visit today?

Do you have any questions that you want answered before you leave here?

Print Form Email Form