

NAME:	DATE:
HEIGHT:                      WEIGHT:	SHOE SIZE:

### CHIEF COMPLAINT

BRIEF DESCRIPTION:	
WHERE IS THE PAIN?	ankle heel arch ball toes
TYPE OF PAIN?	dull/ache sharp shooting burning Numb/Tingling
FOR HOW LONG?	days weeks months years
WHEN?	constant AM PM standing walking sitting exercising
PREVIOUS TREATMENT	ice stretching rest advil/tylenol inserts physical therapy
<b>LIST OTHER COMPLAINTS YOU WOULD LIKE ADDRESSED</b>	
1	
2	

### PAST MEDICAL HISTORY (*circle relevant*)

<b><u>HEART</u></b> Arrhythmia Congestive Heart Failure Heart Attack Heart Murmur Pacemaker Defibrillator	<b><u>VASCULAR</u></b> Stroke Claudication (Leg fatigue) High Blood Pressure Blood clots/ DVT/ PE High Cholesterol High Triglycerides	<b><u>LUNGS</u></b> Asthma Emphysema COPD Tuberculosis Sleep Apnea
<b><u>HEMATOLOGIC</u></b> Clotting disorder Anemia Cancer HIV/AIDS	<b><u>ENDOCRINE</u></b> Thyroid disorder Parathyroid disorder Diabetes Mellitus Type I Diabetes Mellitus Type II Diabetes Insipidus	<b><u>GENITOURINARY</u></b> Kidney Disease Dialysis Prostate Cancer BPH Pregnant
<b><u>GASTROINTESTINAL</u></b> Jaundice Cirrhosis Hepatitis Reflux GI Ulcers	<b><u>DERMATOLOGICAL</u></b> Wounds Rash Athlete's foot Fungal nails Psoriasis Keloids	<b><u>PSYCHIATRIC</u></b> Anxiety Depression Bipolar ADD / ADHD OCD
<b><u>MUSCULOSKELETAL</u></b> Joint pain / swelling Joint Replacement Osteoarthritis Back Pain Muscle ache or fatigue Gout	<b><u>RHEUMATOLOGICAL</u></b> Rheumatoid Arthritis SLE / Lupus Raynaud's Disease Connective Tissue Disease Fibromyalgia	<b><u>NEUROLOGICAL</u></b> Paralysis Seizures Numbness /Tingling Loss of Balance Migraines / Headaches Parkinson's Dementia

### MEDICATIONS/DOSE

1	5	9
2	6	10
3	7	11
4	8	12

### ALLERGIES/REACTION

1	Rash Hives Anaphylaxis Nausea Other:	
2	Rash Hives Anaphylaxis Nausea Other:	
3	Rash Hives Anaphylaxis Nausea Other:	
4	Rash Hives Anaphylaxis Nausea Other:	

### SOCIAL HISTORY

			What kind? How much? How often?
Do you smoke?	Yes	No	
Did you ever smoke?	Yes	No	
Do you drink alcohol?	Yes	No	
Illicit drug use	Yes	No	
Do you exercise?	Yes	No	

### PAST SURGERY

PROCEDURE	REASON	DATE

### FAMILY HISTORY

	Father	Mother	Brother	Sister
<b>Heart Problems</b>	Father	Mother	Brother	Sister
<b>High Blood Pressure</b>	Father	Mother	Brother	Sister
<b>Diabetes</b>	Father	Mother	Brother	Sister
<b>Cancer</b>	Father	Mother	Brother	Sister
<b>Clotting disorder</b>	Father	Mother	Brother	Sister