NEW PATIENT APPLICATION

Legal Name _____ Preferred Name _____

Birth Date _____/_____/_____ Age _____ Height _____ Weight _____

Cell Phone _____ Address _____

Email _____ _____

Occupation (Current or Previous) _____ Retired? Yes No

Marital Status: S M D W Spouse Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Are there any other family members/friends who are involved in your health/financial decisions?

If so: Name/Contact Information _____

How did you hear about our office? TV Facebook Seminar Mailer Other: _____

What is your main health concern for this appointment? _____

When did your symptoms begin? _____

Is there anything that makes it worse? _____

Is there anything that makes it better? _____

Please check the following symptoms if they apply to you…

- ☐ Foot Pain
- ☐ Foot Numbness
- ☐ Foot Surgery
- ☐ Leg Pain
- ☐ Hand Pain
- ☐ Hand Numbness
- ☐ Arthritis Hands/Feet
- ☐ Vascular Problems
- ☐ Deep Vein Thrombosis
- ☐ Poor Circulation
- ☐ Poor Wound Healing

- ☐ Low Back Pain
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Herniated Disc
- ☐ Spinal Stenosis
- ☐ Spinal Arthritis
- ☐ Degenerative Disc Disease
- ☐ Bulging Disc
- ☐ Joint Replacement
- ☐ Plantar Fasciitis

- ☐ Pacemaker/Defibrillator
- ☐ Implanted Cord/Bladder Stimulator
- ☐ Balance Issues / Falls
- ☐ Neck Pain
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Morton’s Neuroma

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How would you describe your symptoms?

- ☐ Aching Pain
- ☐ Balance Issues / Falls
- ☐ Burning
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Cramping
- ☐ Dead Feeling
- ☐ Electric Shocks
- ☐ Heavy Feeling
- ☐ Hot Sensation
- ☐ Numbness
- ☐ Pins & Needles
- ☐ Sharp Pain
- ☐ Stabbing Pain
- ☐ Swelling
- ☐ Throbbing Pain
- ☐ Tingling
- ☐ Tiredness

How would you describe the overall physical appearance of your feet and legs?

- ☐ Blisters or Sores
- ☐ Cyanosis (Blue or Purple Skin)
- ☐ Discoloration of Skin (Red or Pale)
- ☐ Discoloration of Toe Nails
- ☐ Dry or Flaky Skin
- ☐ Fungus (on skin or nails)
- ☐ No Hair Growth
- ☐ Loss of Toe Nails
- ☐ Petechiae (Red Spots)
- ☐ Other _____

How have your symptoms changed over time? Gotten Worse Stayed the Same Gotten Better

How frequent is your discomfort?

Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

Is there a certain time of day that the symptoms seem to be worse?

Morning _____ Mid-Day _____ Evening _____ Overnight _____ N/A _____

On an average day this past week, how severe would you rate your overall discomfort level?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Worst Discomfort Possible

If you still experienced some level of discomfort after completion of this program, what would be an acceptable level?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Worst Discomfort Possible

On a scale of 1-10, how committed / serious are you about getting your health concern corrected?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

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Does your condition interfere with your ability to perform any of the following?

- ☐ Daily Activities _____
- ☐ Exercise _____
- ☐ Hobbies _____
- ☐ Relationships
- ☐ Sleep
- ☐ Standing
- ☐ Walking
- ☐ Working

How many doctors have you seen for this condition? _____

Please indicate which of the following you have used to try to relieve your symptoms

- ☐ Advil / Ibuprofen
- ☐ Aleve / Naproxen
- ☐ Amitriptyline
- ☐ CBD / Hemp products
- ☐ Chiropractic Care
- ☐ Creams
- ☐ Cymbalta
- ☐ Gabapentin
- ☐ Injections
- ☐ Lyrica
- ☐ Massage Therapy
- ☐ Motrin
- ☐ Neurontin
- ☐ Opioids
- ☐ Physical Therapy
- ☐ Tylenol / Acetaminophen
- ☐ Other _____

Have the things you have tried so far helped? __ Yes, a lot __ A little __ Not at all __ Unsure

Primary Care Physician Name _____

Clinic Name / Phone Number _____

Do we have your permission to send them records of your visits here if they request us to? Yes No

Please list all **prescription medications** you are currently taking (or provide us with a list we can copy)

_____ _____

_____ _____

_____ _____

Are you currently taking a **blood thinner**? (Coumadin, Lovenox, Heparin, etc.) Yes No

Are you currently taking a **statin**? (Atorvastatin, Lipitor, Crestor, Simvastatin, etc.) Yes No

Please list all **allergies and sensitivities** below

_____ _____

_____ _____

_____ _____

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Please list all **supplements** (vitamins, herbs, etc.) you currently take (or provide us with a list to copy)

_____ _____

_____ _____

Please list all **serious medical conditions or surgeries** you currently have or have had in the past with approximate dates if applicable.

_____ _____

_____ _____

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily # _____ ☐ Former User

Tobacco Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily # _____ ☐ Former User

Other Drug Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily ☐ Former User

Do you exercise regularly? Yes No If yes, what and how often? _____

Please list 2-4 activities you can no longer do or are struggling with because of your condition.

_____ _____

_____ _____

What do you feel your life will be like in the next few years if this problem continues to get worse?

_____

_____

How would your life be different if you no longer had this problem or if it were to improve?

_____

_____

What would need to happen in order for you to consider your treatments here to be successful?

_____

_____

By signing this form, I…

- Certify that all information I have listed is accurate and complete to the best of my knowledge
- Agree to allow the doctor to discuss any relevant information with other practitioners or staff in order to better serve me.

_____ _____

Patient Signature Date