

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