

East Bay Foot Clinic, Inc.- New Patient Intake Form

PatientName: _____

Today's Date: ____/____/____ DOB: ____/____/____

Age: _____ Sex: M F

Home Address: _____

City/State: _____ Zip: _____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

E-Mail: _____

Primary Language: _____

Do you have a legal guardian or power of attorney? Yes No If yes, please provide legal documentation.

Emergency Contact: _____

Phone: _____

Primary Care Doctor: _____

Pharmacy: _____

Phone: _____

Who is responsible for payment? _____

Insurance Information

Primary Insurance: _____

Member ID: _____

Secondary Insurance: _____

Member ID: _____

Your Medical History

Do you have any allergies to any of the following?

Medications, Anesthesia, Tape, Latex, Iodine, Other No Known Drug Allergies

Please list all medications you are allergic to:

Medication	Reaction	Allergy Notes

Please list all medications you are currently taking:

Medication	Dosage	Medication notes

Have you ever been diagnosed with the following:

	Yes	No		Yes	No	Diagnosis notes
Anemia			Cancer			
Arthritis			Diabetes T1 T2			
Abnormal Bleeding			Fibromyalgia			
Back Problems			Gout			
Blood clots			Heart Attack			

High Blood pressure	Yes	No	Low Blood pressure	Yes	No	Diagnosis notes
Kidney Disease	Yes	No	Open Sores	Yes	No	
Liver Disease	Yes	No	Stroke	Yes	No	

Current Problem

What specific problem brings you to our office today?

How long ago did this problem start? _____ days / weeks/ months / years

Did your pain or problem begin: All of a sudden Gradually develop over time

How would you describe your pain? (Please Circle)

No pain Sharp Dull Aching Burning Radiating Itching Stabbing

How would you rate your pain on a scale from 1 to 10?

0 1 2 3 4 5 6 7 8 9 10

Since the time your pain or problem began, has it: (Please Circle)

Stayed the same Become worse Improved

What makes your pain or problem feel worse? (Please Circle)

Improved Walking Standing Daily activities Resting Dress shoes High heels

Flat shoes Closed toe shoes

What makes your pain or problem feel better?

What treatments have you had for this problem?

How has this problem affected your lifestyle or ability to work?

Was this problem caused by an injury? Yes No Please describe

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print Name of Patient _____

Signature of Patient _____

Date Signed _____