NEW PATIENT/CONSULTATION FORM

Patient Information, Medical History and Lower Extremity Examination

DATE: ____/____/____ E-Mail Address ____________________

NAME: Last ____________________ First ____________________ Initial ______

AGE: ______ SEX: ☐ male ☐ female Date of Birth: ____/____/____ Social Security # ____-____-____

Referred By: ☐ Dr. ☐ Mr. ☐ Ms. ____________________ Personal Physician: ____________________

Date of Last Visit: ____/____/____

Mailing Address ____________________ City ____________________ Zip ____________

Home Phone ____________________ Employer ____________________ Occupation ____________________

Employer Address ____________________ Tele/cell too ____________________

Spouse's Name ____________________ Employer ____________________

Party Responsible for Account ____________________

Address (if different) ____________________

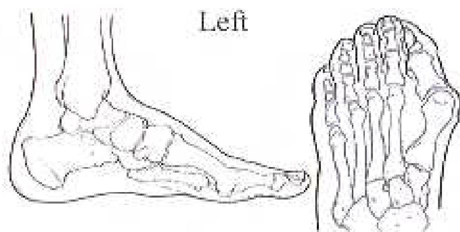
Insurance Company(ies) Name ____________________

Group Number(s) ____________________ Policy Number(s) ____________________

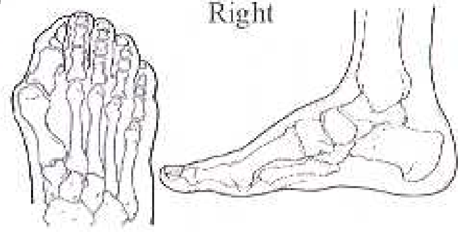
In Case of Emergency, Notify: ____________________ Telephone ____________________

Current Problems: (Location, Duration, Onset, Cause, Aggravating Factors, Previous Treatment)

Length of time for current problem: ________ ☐ days ☐ weeks ☐ months ☐ years



Please use circles and arrows to indicate painful, injured or problem area(s)



PATIENT NAME: ____________________

ACCOUNT NUMBER: ____________________

PAST MEDICAL HISTORY

Current Medications List:

Are you currently taking any of the following:

☐ Echinacea ☐ Garlic ☐ Ginger ☐ Gingko Biloba ☐ St. John's Wort ☐ Ginseng ☐ Kava kava ☐ Feverfew ☐ Ephedra

Immunization Status:

☐ Polio (OPV or IPV) ☐ DPT/DTaP ☐ Measles ☐ MMR ☐ Hep B (3 doses) ☐ Varicella

Tetanus Status: ☐ Current ☐ Over 5 years ☐ Over 10 years ☐ Unknown

Vital Signs:

(office use)

Height: ___ feet ___ inches Weight: ____ lbs. Resp: ____ Pulse: ____ B.P.: ___ / ___ Temp: _____ ° F.

Allergies:

☐ Penicillin ☐ Sulfa drugs ☐ Aspirin ☐ Codeine ☐ Iodine/Shellfish ☐ Tape

☐ Local anaesthetics ☐ General anaesthetics ☐ Latex

☐ Other antibiotics ☐ Other pain medications ☐ Non-steroidal medications

Medication allergies: ____________________

Food allergies: ____________________

Environmental allergies: ____________________

Previous Injuries:	Previous Surgeries:	Previous Hospitalizations:

PATIENT NAME: ______________________

ACCOUNT NUMBER: ____________________

ILLNESSES

MAJOR DISEASE:
- ❑Diabetes
- ❑Hypertension
- ❑Angina
- ❑Heart Disease
- ❑Heart Attack
- ❑Arrhythmia
- ❑Murmur
- ❑Mitral Valve Prolapse
- ❑Stroke
- ❑Chest Pain

HEENT:
- ❑Headaches
- ❑Eye Problems
  Glasses
- ❑Hearing Problems

RESPIRATORY:
- ❑Asthma
- ❑Bronchitis
- ❑Frequent Colds
- ❑Lung Disease
- ❑Shortness of Breath
- ❑Tuberculosis
- ❑Emphysema

ARTHRITIS:
- ❑Osteoarthritis
- ❑Rheumatoid
- ❑Gout
- ❑Sero-negative: Reiter's, PsA, Anklyosing Spondylitis, CCPD, Irritable Bowel

VASCULAR:
- ❑Anemia
- ❑Sickle Cell
- ❑Bleeding Disorders
- ❑Poor Circulation
- ❑Night Cramps
- ❑Leg Pain When Walking
- ❑Vein Problems
- ❑Spider Veins
- ❑Varicose Veins
- ❑Swelling Phlebitis
- ❑Leg Ulcerations
- ❑Blood Clots
- ❑Transfusions

GASTROINTESTINAL:
- ❑Ulcers
- ❑Bowel Disorders
- ❑Stomach Problems
- ❑GI or Rectal Bleeding
- ❑Hiatal Hernia
- ❑Acid Reflux (GERD)

MISCELLANEOUS:
- ❑Epilepsy
- ❑Thyroid Disease
- ❑Muscle Disease
- ❑Kidney Problems
- ❑Bladder Problems
- ❑Prostate Problems
- ❑Venereal Disease
- ❑Skin Conditions
- ❑Cancer History
- ❑Hepatitis

PSYCHOLOGICAL:
- ❑Anxiety
- ❑Depression
- ❑Psychiatric Conditions
- ❑Drug Dependence
- ❑Alcohol Dependence

OTHER ILLNESSES:

____

SOCIAL HISTORY:

Occupation: ______________________

Athletic Activities: ______________________

☐ Single
☐ Married

Alcohol:_______ oz/day/week

Tobacco: ____pks/d for___yrs

FAMILY HISTORY: ______________________

I hereby give my permission to Dr. Burrell to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party ______________________ Date ____/____/____