Arizona Foot & Ankle Specialists, LLC
Medicine & Surgery of the Foot, Ankle & Lower Leg

Date:	Patient # (office only)

PATIENT INFORMATION

Name: Last First MI

❑ Male ❑ Female	Marital Status (please circle one) Single | Married | Divorced | Separated | Widow	**Email Address:**	Is it OK to send emails? ❑ Newsletter ❑ Offers ❑ Neither

Street Address:	City:	State:	Zip:

Home Phone:	Work Phone: Ext.	Cell Phone:
Is it OK to leave messages at home? ❑ Yes ❑ No	Is it OK to leave messages at work? ❑ Yes ❑ No	Cellular privacy: ❑ Only 1 user, me ❑ OK to leave messages

Race: ❑ African American ❑ Amer. Indian/Alaska Native ❑ Asian ❑ Hispanic ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other	Ethnicity: ❑Hispanic/Latino ❑ Non-Hispanic/Latino	Language: ❑ English ❑Spanish ❑ Other _____

Social Security Number: - -	Date of Birth: / /	Age:	Insurance Status ❑ Currently Insured ❑ Paying Cash

Employment Status: ❑ Full time ❑ Part time ❑ Retired ❑ Student ❑ Unemployed ❑ Self-employ ❑ Disabled ❑Other__

Primary Care Provider (PCP): Dr. Date of last visit: / /

Preferred Pharmacy: Address/Cross Roads:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary insurance: ❑ Aetna, ❑ AHCCCS-Mercy Care, ❑ AHCCCS-United HealthCare, ❑ AHCCCS-Health Choice, ❑ Ambetter/Healthnet, ❑ Arizona Foundation, ❑ Blue Cross/Blue Shield AZ, ❑ BC/BS Federal, ❑Bright Health, ❑ CIGNA, ❑GEHA, ❑ Healthnet Military, ❑ Medicare/CMS, ❑ Meritain, ❑ Mercy Care Advantage, ❑ Southwest Service Admin, ❑ United HealthCare, ❑ Other _____

Subscriber's name:	Subscriber's SSN: - -	Birth date: / /	Group #:	Policy #:

The subscriber is the patient's ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

Secondary insurance (if applicable)	Subscriber's name:	Group #:	Policy #:

The subscriber is the patient's ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

Name of person responsible for bill:	Date of Birth: / /	Phone #:	Occupation:

Street Address:	City:	State:	Zip:

Employer:	Employer City & State:	Employer Phone:

EMERGENCY CONTACT

Name of contact (not living at the same address):	Relationship:	Primary phone #:	Secondary phone #:

REFERRED BY:

How did you hear about us? ❑ Primary Care ❑ Other doctor, Dr._____ ❑ Insurance ❑ Hospital ❑ Friend ❑ Relative ❑ Patient ❑ Our website ❑ Web search (Google, Yahoo, Yelp, etc.) ❑ Saw the sign ❑ Other

Other family members seen here: ❑ Spouse ❑ Parent ❑ Child ❑ Other_____

SIGNATURE/RELEASE OF BENEFITS INFORMATION

To the best of my knowledge the above information is correct. I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I also understand that it is not the doctor's office responsibility to inform me if the services provided are covered by my insurance. I authorize the release of information required to process my claims. (If not signed below, payment is due at the time of service)

ALL CO-PAYMENTS AND DEDUCTIBLE AMOUNTS DUE ON DAY OF SERVICE.

Patient Signature:_____ Date:_____

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

INSURANCE/PRACTICE POLICIES AGREEMENT

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

_____**INSURANCE BENEFITS:** I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Arizona Foot & Ankle Specialists, LLC. My insurance company may not cover my charges for any of the following reasons: referral was not valid for care, my insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to deductible/coinsurance/copay. The doctors and staff of Arizona Foot& Ankle Specialists, LLC will file my insurance when appropriate, but I will ultimately be responsible for all charges and knowing my insurance benefits. A fee schedule can be obtained upon request. Acceptable payments that we take for copayments, deductibles, and coinsurance are cash and all major credit cards. We do not accept checks for any of the above.

A) ____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

B) ____**DEDUCTIBLES & CO-INSURANCE:** If you have a deductible plan, we will collect on the services rendered and apply it towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

C) ____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required prior to the time of your visit. Without a referral available, your appointment will be rescheduled, or you may be seen as a cash pay patient without insurance benefits.

_____**SELF-PAY:** Full payment is due at the time of service. A down payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the provider but you will be informed of these charges before proceeding with treatment.

_____**BALANCES/COLLECTION FEES:** I understand that payment is due at the time of service if I have no insurance, for non-covered services by my insurance, and/or any copays/deductibles/coinsurance, or any OTC/in-office purchases. I understand that if I receive a statement for services rendered, this amount is due within 30 days. There will be a $20 late fee for balances over 90 days. Accounts due more than 120 days will be charged to your card on file or turned over to our collection agency. There will be an additional mark up of 40% to the balances. There will also be an additional $50 reinstatement fee to be seen in the office once the collections are paid off. We accept cash, checks, and all major credit cards.

_____**DURABLE MEDICAL EQUIPMENT (DME):** I understand that if for any reason my insurance carrier has denied payment due to any of the reasons listed above, it is my responsibility to know my insurance benefits and reimburse Arizona Foot & Ankle Specialists for the cost of dispensed DME equipment. DME equipment includes but is not limited to orthotics, AFO braces, crutches, TENS units, tape, gauze, etc. If there is any question as to what is considered DME equipment I understand that I must ask the doctor or staff of Arizona Foot & Ankle Specialists, LLC prior to the dispensing of this item. I understand that all DME equipment is **non-refundable**.

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

INSURANCE/PRACTICE POLICIES AGREEMENT (Continued)

_____**NO SHOW/RESCHEDULE:** A 24-hours' notice is required for cancellation or rescheduling of your appointment and failure to do so will incur a $50 fee. Failure to show up to an appointment with no notice will also result in a $50 fee. Leaving within 60 minutes of your appointment time will also result in A $35 fee. These will not be covered by your insurance company and are the patient's responsibility. A 24-hours' notice is also required for cancellation of any EPAT appointments and failure to do so will incur a $100 fee.

_____**SURGERY CANCELLATION:** Failure to provide 3 business days' notice of cancellation prior to scheduled surgery date will incur a $250 fee. Surgery will not be rescheduled until this is paid.

_____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a $50 charge for completion of FMLA or disability forms that need to be filled out by the provider. Copies of medical records are available at a cost determined by the state of Arizona and a disk with x-ray files is $12. Each additional set of documents will also require additional charges.

_____**OTC/IN-OFFICE PURCHASES:** Products not covered by insurance sold over-the-counter at the front desk are the patient's responsibility and cash will be collected at the time of dispensing, which is **non-refundable**. This includes, but is not limited to, items such as creams, solutions, CBD, wound care products, and non-custom insoles.

I have read and understand these financial policies.

Patient Name (Print): _____

Patient/Responsible Party Signature: _____

Date: _____

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

CONSENT TO RELEASE INFORMATION

Due to the Health insurance Portability and Accountability Act of 1996 (HIPAA) your private medical information is kept in confidence. We are allowed to speak to your doctors and insurance companies under this HIPAA policy, however we cannot and will not speak to anyone else about your medical condition or treatment without your written permission. This includes appointment and billing information. Please print the name and relationship below of anyone who we are allowed to discuss your medical condition or treatment with either now or in the future. You can always add, remove, or update this list in writing in the future.

NAME/RELATIONSHIP OF INDIVIDUALWE CAN SHARE YOUR MEDICAL INFORMATION WITH:

NAME	RELATIONSHIP/PHONE NUMBER
_____	_____
_____	_____
_____	_____

PERMISSION TO TREAT/RELEASE OF INFORMATION/PRIVACY PRACTICES

1. I hereby give my permission to Arizona Foot & Ankle Specialists, LLC to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my extremity condition.
2. I hereby assign to Arizona Foot & Ankle Specialists, LLC benefits provided by my insurance company policy/policies for medical & surgical care.
3. I hereby acknowledge receipt of Notice of Privacy Practices. I have been provided a copy of the Notice of Privacy Practices (available on website & posted in office) and I have read (or had the opportunity to read if I so choose) and understand the notice.
4. I authorize Arizona Foot & Ankle Specialists, LLC to call me for appointment reminders/changes, follow-up of treatment or any outstanding issues with my account.

_____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

_____

PRINT NAME

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION FOR PODIATRY SERVICE

ASSIGNMENT OF BENEFITS

In order to submit a claim to us for services under your policy, we must have your authorization to release medical information to your carrier. As a Medicare participation provider, Arizona Foot & Ankle Specialists, LLC doctors and staff will accept assignment. Even though services may be approved by your insurance there is no guarantee of payments. According to Medicare Guidelines, the provider will always accept the amount that Medicare approves with excess charges to be billed to secondary carriers, including Medigap if applicable.

MEDICARE AUTHORIZATION

I request that payment of authorized benefits may be made to Arizona Foot & Ankle Specialists, LLC. I authorize any holder of Medical Information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Arizona Foot & Ankle Specialists, LLC and information regarding Medicare claims under the Title XVIII of the Social Security Act.

PRIMARY & SUPPLEMENTAL INSURANCE

I hereby authorize the release of any information necessary to file a claim with the insurance company and assign benefits to Arizona Foot & Ankle Specialists, LLC doctors and staff. This includes any coverage under Medigap.

For patients with Medicare: Medicare makes payments only after a yearly deductible has been satisfied.

For patients with both Medicare and Medicaid: Medicaid does not pay the Medicare annual deductible amount, this will be billed to the patient or responsible party.

For patients with Medicaid: Medicaid does not pay for this service.

For patients with Preferred Senior Care: Preferred Senior Care is not expected to pay for this service. Patient or responsible party agrees to pay all charges not covered by Medicare, Medicaid, Medigap, VA or other insurance. Medicaid does not cover podiatry services after age 18, therefore all Medicaid will be charged to the patient or responsible party.

Failure to pay charges is agreed to imply discontinuation of this podiatry service.

_____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

_____

PRINT NAME

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Arizona Foot & Ankle Specialists, LLC and that I have read or had the opportunity to read, (If I so choose to) and understand the Notice.

PATIENT NAME

DATE

PARENT OR AUTHORIZED REPRESENTATIVE (If Applicable)

PATIENT SIGNATURE

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

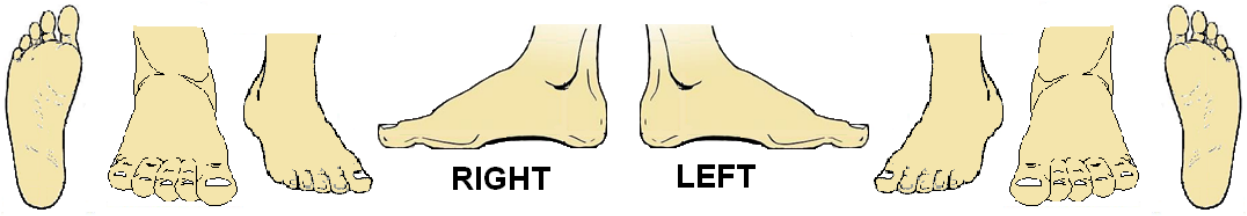
REASON(S) FOR VISIT: What are your foot problems? In simple phrases or sentences write why you are here today **and/or** check the boxes below. _____

❑Ankle pain ❑Heel Pain ❑Arch Pain ❑Pain in the ball of the foot ❑Toe pain ❑Bump pain ❑Bunion Pain
❑Fracture ❑Injury ❑Hammertoes ❑Ingrown Nail(s) ❑Abnormal nail(s) ❑Fungal nail(s) ❑Athlete's foot
❑Itchy feet ❑Foot odor ❑Wound ❑Diabetic Foot Exam ❑Soft Tissue Mass ❑Skin Lesion ❑Wart(s)
❑Calluses and/or corns ❑Fissures/cracks in the skin ❑Burning ❑Tingling ❑Numbness ❑Pins & Needles

CHIEF COMPLAINT: If the doctor can only address one of the issues above today, what would it be? _____

THE REMAINING QUESTIONS ON THIS PAGE ARE IN REGARD TO THE CHIEF COMPLAINT ONLY

LOCATION: Please put an "x" where the pain is the **worst** (place **one** "x" if possible, or two if the problem exists on both sides) and/or check one of the boxes



❑It starts at the "x" and radiates out ❑It's all over, can't pinpoint a spot

DESCRIBE THE PAIN: ❑Sharp ❑Shooting ❑Stabbing ❑Throbbing ❑Dull ❑Aching ❑Burning ❑Tingling
❑Numbness ❑Pins & needles ❑Constant ❑Off & on ❑No pain ❑Other _____

PAIN SCALE: At its **worst**, how bad is your pain out of 10, with 0 being no pain at all and 10 being the worst pain you can imagine? ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

WHEN THE PAIN OCCURS AT ITS WORST: ❑While wearing shoes ❑With any direct pressure ❑With shoes or barefoot
❑While barefoot only ❑Walking and activity ❑Standing ❑While sitting or standing, bearing weight doesn't change it
❑First steps out of bed ❑After a long day on my feet ❑Other_____

OTHER DETAILS: Is this problem the result of an injury? ❑Yes ❑No ❑Not sure Date of injury: _____
How the injury occurred (if applicable):_____
When did the condition start?_____ The condition is getting ❑worse ❑better ❑staying the same
The condition became apparent ❑Gradually over time ❑At the time of injury ❑Soon after an injury ❑Overnight
❑After starting a new job ❑After a surgery ❑When I started exercising more ❑Other_____
Does the condition limit your activity? ❑Yes ❑No
Prior Treatments (all treatments by yourself or a doctor, any pain medications, "rest" if applicable):

_____

_____

What makes it feel better?_____
What makes it feel worse?_____

Arizona Foot & Ankle Specialists, LLC

Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICAL PROBLEMS LIST: (Please check the boxes for any of the problems you have now or in the past.)

❑Anemia
❑Arthritis, Degenerative
❑Arthritis, Rheumatoid
❑Artificial Heart Disease
❑Artificial Joint _____
❑Asthma
❑Autism
❑Blindness
❑Brain Injury/Tumor/Concussion
❑Cancer Location:_____
❑Charcot foot ❑right ❑left
❑Charcot Marie Tooth Disease
❑Circulatory Problems
❑COPD
❑Current Menopause
❑Cystic Fibrosis
❑Diabetes ❑Requiring insulin
❑Epilepsy (seizure disorder)
❑Fibromyalgia
❑Gout
❑Heart Attack ❑In last 6 months
❑Heartburn (Acid Reflux/GERD)
❑Heart Disease
❑Hemophilia
❑High Blood Pressure/Hypertension
❑High Cholesterol
❑HIV Positive
❑Hyperglycemia "pre-diabetic"
❑Hyperthyroid
❑Hypothyroid
❑Kidney Disease ❑On dialysis
❑Liver Disease (Hepatitis)
❑Lower Back Pain/Problems
❑Lung/Respiratory Disease
❑Mental Illness
❑Multiple Sclerosis
❑Muscular Dystrophy
❑Neuropathy, peripheral
❑Post Menopause
❑Psoriasis
❑Rheumatic Fever
❑Sciatica, affecting ❑Right Side ❑Left Side
❑Sickle Cell ❑Trait ❑Disease
❑Stomach Ulcers
❑Stroke/Cardiovascular Accident ❑TIA
❑Tuberculosis
❑Vision Loss ❑Glasses ❑Contacts
❑Other: _____
❑Other: _____

CURRENT MEDICATIONS AND DOSAGES

❑ **No Current Medications Being Taken**

Medications	**Dosages**	**Medications**	**Dosages:**
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

ALLERGIES/DRUG INTERACTIONS: ❑**No Known Allergies**

❑Aspirin ❑Dairy ❑Iodine ❑Peanuts ❑Seasonal Allergies
❑Adhesive Tape ❑Blood thinners ❑Demerol ❑LATEX ❑Penicillin ❑Sulfa
❑Local Anesthetics ❑Codeine ❑Eggs ❑Seafood ❑Other_____

SURGERIES/HOSPITALIZATIONS: ❑ **No Prior History of Surgeries or Hospitalizations**

❑No Prior Foot/Ankle Surgeries
❑Amputation _____
❑Neuroma ❑Right ❑Left
❑Bunionectomy ❑Right ❑Left
❑Hammer Toe ❑2,3,4,5 Right ❑2,3,4,5 Left
❑Joint replacement:_____
❑Chemotherapy/location:_____
❑Gallbladder surgery
❑Appendectomy
❑Gastric bypass
❑Cesarean section
❑ Angioplasty/stent
❑Pacemaker/Defibrillator
❑Heart bypass surgery
❑Heart valve replacement
❑Lower extremity bypass
❑Transplant:_____
❑Radiation/location:_____
❑Back/Spine Surgery
❑Blood transfusion
❑Pacemaker
❑Tonsillectomy
❑Hysterectomy

I agree that to the best of my knowledge, the above information is complete and accurate.

Signature:_____ **Date**:_____

Arizona Foot & Ankle Specialists, LLC
Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY:

Smoking: Are you a? ❑never smoker ❑current smoker ❑former smokers: → When did you quit?_____
If you smoke(d), how many years collectively have you smoked in your life? _____ How many packs per day average?_____
Current Smokers: How much do you smoke? ❑casual smoker (less than 1 cigarette/day) ❑light smoker (1-9 cigs/day) ❑moderate smoker (10-19 cigs/day) ❑heavy smoker (20-39 cigs/day) ❑chain smoker ❑pipe smoker ❑Chews tobacco ❑former smokers Have you used smokeless tobacco products? ❑Never ❑Currently ❑Previously and quit

Alcohol: Have you had a drink of alcohol in the past year? ❑Yes ❑No → If yes, then: How often did you have 6 or more drinks on one occasion in the last year? ❑Never ❑Less than monthly ❑Monthly ❑Weekly ❑Daily/almost daily
How many drinks did you have on a typical day when you were drinking? ❑1-2 ❑3-4 ❑5-6 ❑7-9 ❑10 or more
How often did you have a drink containing alcohol in the past year? ❑Never ❑Monthly or less ❑2-4 times a month ❑2-3 times a week ❑4 or more times a week

Drugs: Have you done any illicit drugs? ❑No/Never ❑Yes/Currently ❑Yes/Previously & quit → If yes, then how often: ❑Daily or almost daily ❑Weekly ❑Monthly → What drug? ❑Marijuana ❑Cocaine ❑Crack cocaine ❑Methamphetamine ❑Heroin ❑Other___

Marital Status: ❑Single ❑Married ❑Divorced ❑Widow/Widower ❑Separated ❑Unwed cohabitating ❑Other: _____

Occupation(s): _____ How many hours a day are you on your feet? _____

Exercise: Do you exercise? ❑No ❑Yes → ❑Never ❑Monthly or less ❑2-4 times a month ❑2-3 times a week ❑4 or more times a week → Which exercises and how often?_____
(If female) Is there a chance you could be pregnant? ❑No ❑Yes, there is a chance ❑Yes, I am pregnant

FAMILY HISTORY:

Do you have a family history of: ☐ Diabetes, ☐ Type 1 ☐ Type 2 ☐ Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other: _____

Please fill out this section if you are covered by WORKER'S COMPENSATION, if you are not then skip this section:
Date of injury:_____
If receiving worker's comp, do you have authorization to see one of our providers? ❑Yes ❑No (please see front desk)
Claim Filed? ❑Yes ❑No Claim number:_____ Where was the claim filed?_____
Adjuster's name:_____ Adjuster's phone number:_____
Cause of injury: _____

I agree that to the best of my knowledge, the above information is complete and accurate.

Signature:_____ **Date**:_____

Arizona Foot & Ankle Specialists, LLC
Medicine & Surgery of the Foot, Ankle & Lower Leg

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Review of Organ Systems: (Check mark NONE if the condition below does not apply to you, otherwise check only **CURRENT** symptoms which are affecting you, write any unlisted symptoms on the previous page)

General/Constitutional
❑NONE
❑Fever
❑Chills
❑Nausea
❑Vomiting
❑Night sweats
❑Weakness

Psychological
❑NONE
❑Anxiety/Nervousness
❑Depression
❑Memory Loss

Head & Neck
❑NONE
❑Migraines/Headaches
❑Dizziness/Faintness ❑when getting up

Eyes
❑NONE
❑Vision Loss ❑Macular Degeneration
❑Blurry vision ❑Double vision
❑Glasses ❑Reading glasses ❑Contacts

Ears, Nose & Throat
❑NONE
❑Hearing loss ❑Hearing aids
❑Loss of voice
❑Problem with anesthesia (please describe on previous page)

Cardiovascular (Heart & Circulation)
❑NONE
❑Chest Pain ❑with increased activity
❑Irregular heart beat (palpitations)
❑Varicose veins
❑Leg pain or cramping at night**
❑Leg calf pain or cramping with walking**

Respiratory (Lungs & Breathing)
❑NONE
❑Shortness of Breath
❑Wheezing
❑Cough ❑Dry ❑Wet ❑Productive
❑Chest tightness
❑Difficulty sleeping while laying down
❑Using a CPAP at night to sleep

Gastrointestinal (Stomach & Bowels)
❑NONE
❑Heartburn (acid reflux/GERD)
❑Stomach ulcers
❑Abdominal pain

Endocrine (Pancreas, Thyroid, Hormones, etc.)
❑NONE
❑Excessive thirst
❑Cold intolerance
❑Unexpected weight change +/-_____

Genitourinary (Kidneys & Reproduction)
❑NONE
❑Frequent urination ____times per night
❑Painful urination ❑Burning urination
❑Incontinence
❑Sexually Transmitted Disease_____

Hematologic (Blood & Lymph System)
❑NONE
❑Bleed easily ❑on blood thinners
❑Bruise easily
❑Anemia
❑Lower extremity swelling ❑Right ❑Left
❑I refuse blood transfusions

Allergic/Immunologic (Immunity)
❑NONE
❑Immunodeficiency (decreased immune response)
❑AIDS ❑On chemotherapy ❑Other
❑Seasonal allergies (allergic rhinitis)
❑Other food, drug or environmental allergies not previously mentioned (please write them on the previous page)

Neurological (Nerves & Sensation)
❑NONE
❑Stroke/Brain injury ❑Spinal cord injury
❑Sciatic pain ❑Right ❑Left
❑Nerve symptoms:
❑Burning ❑Numbness ❑Tingling
❑Pins & Needles ❑funny bone feelings
❑Electrical sensations ❑hypersensitive
❑Lower extremity ❑Right ❑Left
❑Other location_____

Integumentary (Skin & Nails)
❑NONE
❑Foot skin condition already described
❑Sweaty feet (hyperhidrosis)
❑Discolored streaking in toenail(s)
❑Skin lesion ❑Discolored ❑Location:___
❑getting bigger ❑changing shape
❑Wound(s) ❑Location:_____

Musculoskeletal (Bones, Joints, Muscles)
❑NONE
❑Foot/Ankle condition already described
❑Pain in limb
❑Joint pain (check site below)
❑Prior Surgery (check site below)
❑Artificial joint(s) (check site below)
❑Right Knee ❑Pain ❑Prior Surgery
❑Left Knee ❑Pain ❑Prior Surgery
❑Right Thigh ❑Pain ❑Prior Surgery
❑Left Thigh ❑Pain ❑Prior Surgery
❑Right Hip ❑Pain ❑Prior Surgery
❑Left Hip ❑Pain ❑Prior Surgery
❑Lower back ❑Pain ❑Prior Surgery

I agree that to the best of my knowledge, the above information is complete and accurate.

Signature:_____ **Date**:_____