Foot Health Questionnaire

Name ____ Home Phone _________________________________

Address ____ Work Phone ___________________________

City______________________ State________, Zip__________ Cell Phone______________________________

Birth date________________ Age _____ SS#__________________ Male________ Female________

Occupation Employer ____

Employer's Address____Phone # _________________________

Marital Status: M W Sep. D Sin. Spouse Name___________________ No. of Children ____________________

Spouse's Employer ____

Spouse's Birth date: ______________ E-mail Address ____

1. Most patients are referred to our office by a caring family member or friend.

   What made you decide to visit our office?
   ☐ Friend/Family Member Name ☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. When was your last physical?______________________________________ ☐ Never

3. Stress can lead to inflammatory processes that can increase foot pain. Rate your stress level over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High

4. Please list any health symptoms or health complaints you are experiencing.

   1.____

   2.____

   3.____

5. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

6. Is there any chance that you are pregnant? ☐ YES ☐ NO

7. Have you ever been diagnosed with cancer? ☐ YES ☐ NO Type______________________Year __________

8. Do you have an implanted medical device such as a pacemaker? ☐ YES ☐ NO

9. When was your last complete spinal examination including X-rays? _______________________ ☐ Never

10. If the doctor feels that our weight loss program would benefit you, are you willing to follow his/her recommendations?
    ☐ YES ☐ NO

All of the above patient information is true and accurate to the best of my knowledge.

Patient Signature ______________________________ Date ______________________