Patient Name: ___________________________________ **Age:** __________ **Chart #:** _________

Allergies: □ **NO KNOWN ALLERGIES**

List Any Known Allergies and Reaction: ____

____

Medications	Dose (mg)	Frequency (how often)	Reason for taking meds
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please circle ALL that apply:

Work Status: Full Time / Part Time / Unemployed / Retired / Disabled / Student (If Student fill out below)

Name of School: ____________________________ **Sports Activities:** ______________________________

Type of Work: Primarily Seated / Light Duty / Manual Labor

Marital Status: Married / Single / Divorced / Widowed / Separated

Living Situation: / Alone / With Spouse / With Parents /Nursing Home / With Children/ Other: _____________

Referring Physician or Clinic: _________________________ **Family Doctor:** ________________________

Shoe Size (If treating foot or ankle): _______________

Please check below all that apply:

Family History:	**Personal Behavior History:**
☐ Diabetes Mellitus	☐ Alcohol Use
☐ Cancer	☐ Tobacco Use
☐ Heart Disease	☐ Smoker ___Previous ___Current
☐ Hypertension	☐ Snuff ___Previous ___ Current
☐ Arthritis	☐ Never Smoked

R07.19.12