Podiatrist Comments/Summary ~ This box reserved for office use

Date_____ **DRS Signature** _____ D.P.M.

New Patient Podiatric History Form

Dr. Kathleen T. Neuhoff

How did you learn of our office/who referred you to us: _____

PLEASE PRINT

Patient Name _____ Date_____

Age _____Height _____Weight _____Shoe Size _____

CHIEF COMPLAINT ***(Nature of your Foot Pain or Problem):*** _____

_____

_____

Location on Foot or Leg:
check all that apply

- ☐ Forefoot/Toes
- ☐ Ankle
- ☐ Outer Side
- ☐ Middle Foot
- ☐ Top
- ☐ Inner Side
- ☐ Back Part of Foot
- ☐ Bottom

How Long Has This Bothered You? _____
How Did This Begin? _____
What Course has it Taken? _____
What Aggravates it? _____
What Makes it Feel Better? _____
What Have You Done to Relieve the Condition? _____
(If you have gone to another doctor to relieve the pain, please give his/her name)
_____

General Health: If you have had or have any Of the following, check all that apply

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Headaches
- ☐ Lower Back Pain
- ☐ Neck Pain
- ☐ HIV
- ☐ Hip Problems
- ☐ Ankle Problems
- ☐ Skin Problems
- ☐ Bone Fracture
- ☐ Pneumonia
- ☐ Bruise easily
- ☐ Breath shortness on exertion

Please CIRCLE all that apply:

Pain, Cramps, Swelling, Tingling
Burning in Feet—Numbness in Feet
Burning in Legs--- Numbness in Legs

This usually happens:

- ☐ after walking a block
- ☐ while lying in bed
- ☐ after being on feet

How long does this last? _____

Please turn this paper over and complete the questions on the back

Date of your last Flu Shot:_____ Date of your pneumonia vaccination:_____
Can you take aspirin? _____ Have you had a local anesthetic *(such as for dental work)* ? _____
Did you have any problems with it? _____
Please list the prescriptions that you take: _____

_____

_____

Do you smoke? _____ How much? _____ For how long? _____
Do you drink? _____ How much? _____ For how long? _____
Are you using any over-the-counter medications? _____
If so, which ones (names)? _____

_____

Past surgeries or hospitalizations: _____

_____

_____

WOMEN: Are you, to your knowledge, Pregnant? ☐ Yes ☐ No

ALLERGIES

Are you allergic or sensitive to:

☐ Penicillin ☐ Novacaine ☐ Anesthetics
☐ Adhesive Tape ☐ Iodine ☐ Metal
☐ Drugs: _____
☐ Other: _____
☐ I am not allergic to anything that I know of.

FAMILY HEALTH

Have you or any of your family members ever had any of the following *(please check all that apply)*

You	Family		You	Family	
☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Heart Trouble	☐	☐	Nerve Disease
☐	☐	Blood vessel disease	☐	☐	Nervous Condition
☐	☐	High Blood Pressure	☐	☐	Muscle disease
☐	☐	Bleeding Problems	☐	☐	Bone disease
☐	☐	Kidney trouble	☐	☐	Varicose veins
☐	☐	Liver Problems	☐	☐	Arthritis
☐	☐	Anemia	☐	☐	Cancer
☐	☐	Lung disease	☐	☐	Rheumatic fever
☐	☐	Blood disease	☐	☐	Asthma
☐	☐	Lymph Disease	☐	☐	Gout

Any other medications not listed above? _____

_____

_____

I certify that the above information is accurate and true to the best of my knowledge

Signature: _____ **Date** _____

~ Thank You ~

Welcome to our office!

PLEASE PRINT

Today's Date _____

How did you hear about us? _____

Patient Name _____ Do you go by a nickname? _____
Last First MI

Address _____ City _____ ST ____ Zip _____

Date of Birth ___/___/___ SSN _____ Please circle one: Male Female

Email _____ Phone _____ Cell _____

Circle One: Single Married Widowed Separated Divorced
Race: African American Hispanic Caucasian Other
Preferred Language: English Spanish Other: _____

Full time student? Yes No
Ethnicity: Hispanic Non-Hispanic

Occupation _____ Employer _____

Employer address _____
Street City State ZIP

Employer phone number _____ Extension _____

Family Physician Name _____ Date of last visit _____

Endocrinologist _____ Date of last visit _____

Pharmacy Name _____ Location _____

Spouse's Name _____ Date of birth ___/___/___

SSN ___-___-___ Employer Name _____

Employer address _____
Street City State ZIP

Employer phone number _____ Extension _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

Relationship _____ Home phone _____ Work phone _____

Please read and sign regarding Treatment and Medical Records: I hereby give Dr. Neuhoff permission to release copies of my record to any healthcare provider at my request. I also permit the provider of my choice to administer treatment and perform such general procedures as he/she deems necessary in the diagnosis and/or treatment of my lower leg/foot condition(s).

Patient Signature _____ Date _____

Patient signature required unless patient is under the age of 18; then a responsible party MUST sign.

Revised 12.21.2019 waf

Family Foot Care Clinic
727 E. Jefferson Boulevard, South Bend, IN 46617
(574) 287-5859 phone
(574) 287-4987 fax
www.familyfootcareclinic.com

FINANCIAL POLICY

Thank you for choosing Family Foot Care Clinic for your podiatry needs. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our financial policy.

Patient Name: _____ Date of Birth: _____

Please initial:

_____ **All applicable charges are due at time of service. We accept cash, checks and credit cards.**

_____ RETURNED CHECKS
For checks returned to us as unpaid and/or insufficient by the bank, we will charge a $25.00 fee.

_____ MISSED APPOINTMENTS
Office policy states that we will charge for missed appointments not cancelled 24 hours prior to your appointment. A $45.00 fee will be assessed and will be your responsibility. Help us to serve you better by keeping your scheduled appointment.

By signing below, I am acknowledging that I have read and understand the above financial policy and that any questions have been answered by the staff.

Patient name - *please print*	Patient signature	Date
Guarantor name (if patient is a minor) - *please print*	Guarantor signature	Date

Staff Signature

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Family Foot Care Clinic

727 East Jefferson
South Bend, IN 46617
574-287-5859

Notice of Privacy Practices

ACKNOWLEDGMENT FORM

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print) _____ Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____

I authorize Family Foot Care Clinic to share ☐ ***Clinical and/or*** ☐ ***Financial*** information with:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____