SELAH
NATURAL MEDICINE

8375 SW Beaverton Hillsdale Hwy, Suite C
Portland, OR 97225
p: 503.206.6996
f: 888.959.9018

www.selahnaturalmedicine.com

Adapted from NWfootankle.com
** The information on this form is necessary for our office to obtain prior to your initial office visit. If this form is not competed in its entirety, you will be delayed in seeing the doctor until the form is complete. Please write on the back if more room is needed. Thank you for your cooperation.

PODIATRY EVALUATION INTAKE FORM

PATIENT INFORMATION: Please complete ALL of the following entries!

Today's Date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Home Phone: _____ Cell/Mobile Phone: _____ Email Address_____

Address: _____ City, State, Zip: _____

Marital Status: Single _____ Married _____

Employer: _____ Occupation: _____ Work Phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest relative address: _____

Emergency Contact: _____

Relationship: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Date last seen by PCP: _____

Pharmacy: _____ Pharmacy Phone: _____

How did you find out about us/Who may we thank for referring you to our office? _____

May we contact you via email for feedback, updates and newsletters? ☐ Yes ☐No

PATIENT COMPLAINTS: Check ALL that apply

☐ Headaches ☐ Right foot ☐ Left foot ☐ Corns ☐ Flat feet ☐ Calluses ☐ Pain in heels
☐ Soft corns ☐ Back aches ☐ Thick nails ☐ Warts ☐ Knee pain ☐ Ankle sprains ☐ Bunions
☐ Ingrown toe nail ☐ Leg cramping ☐ Feet cramping ☐ Other _____

Please explain your current foot or ankle problem: _____

_____

_____

When did the problem start? _____

What has been done to treat the problem? _____

Is this injury work related? How? _____

PATIENT HEALTH INFORMATION:

Weight: _____ Height: _____

Shoe Size: _____ Width: _____

How is your general health? Good ☐ Fair ☐ Poor ☐

	Yes	No
Do you have a history of low back pain?	☐	☐
Are you regularly tired and exhausted?	☐	☐
At work, do you spend more than 30% of your time on your feet?	☐	☐
Did anyone in your family (mother, father, Grandparents) have similar foot problems?	☐	☐
Have you been treated by a doctor in the past 2 years?	☐	☐
Are you subject to prolonged bleeding?	☐	☐
Is there a family history of diabetes?	☐	☐
Do you smoke cigarettes?	☐	☐
If yes, how many per day? _____		
Have you ever fainted in a doctor's or dentist's office?	☐	☐
Have you had previous care by a podiatrist?	☐	☐
Date last seen: _____		
Dr's Name: _____		
Is your current pain/injury keeping you from regular activities?	☐	☐

Have you ever been treated for any of the following?

☐ Epilepsy/Seizures ☐ Gout ☐ Heart Disease
☐ Stomach ulcer ☐ Stroke or Heart Attack
☐ Phlebitis ☐ Diabetes ☐ Anemia
☐ Kidney Bladder ☐ Difficulty in healing
☐ Liver Disease ☐ Rheumatic fever
☐ Thyroid Disease ☐ Tuberculosis
☐ Shortness of breath ☐ High/low blood pressure
☐ Depression or Anxiety ☐ Accident/Injury
☐ Vascular/Circulatory Disease ☐ Cancer
☐ Immune Disease (HIV, AIDS, Hepatitis ☐A, ☐B, ☐C)

Have you experienced any ill effects from any of the following?

☐ Penicillin ☐ Aspirin ☐ Cortisone
☐ Sulfa Drugs ☐ Novacain ☐ Tape
☐ Codeine ☐ Any antibiotics
☐ Latex ☐ Peanuts

Others, please list: _____

_____

Are you ***allergic*** to any medications?

If yes, please list ALL: _____

_____

SERIOUS ILLNESSES:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

SURGERIES and HOSPITALIZATIONS:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

MEDICATIONS/Vitamins, Supplements, and over-the-counter products such as Advil, Tylenol, etc. (include dosage of each):

This section is important…Please do not skip!! ***If a list is available, please give to the receptionist in order for us to make a copy for your records.***

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

For Office Use ONLY