



332 W. Montauk Hwy Ste 3

Hampton Bays, NY 11946

☎ 631-287-1818

📠 631-994-3188

1. Please enter your information.

First Name: _____ Last Name: _____ Date of Birth: _____ Sex: ☐ Female ☐ Male

Marital Status:
☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Preferred contact method:
☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

2. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Sex ☐ Female ☐ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

3. Secondary Insurance

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

4. Who is your primary care physician? And Date last seen

5. What is your shoe size (Length and Width)

6. Past Medical/Surgical History

- | | | |
|--|---|---|
| ☐ None | ☐ Atrial Fibrillation | ☐ Anemia |
| ☐ Alzheimer's disease | ☐ Arthritis, rheumatism | ☐ Artificial heart valves |
| ☐ Artificial joints, pins, etc. | ☐ Asthma | ☐ Bleeding abnormally |
| ☐ Back Problems/Back Pain | ☐ Benign Prostatic Hypertrophy | ☐ Cancer |
| ☐ Circulatory problems | ☐ Cataracts | ☐ Depression/Anxiety |
| ☐ Diabetes | ☐ Epilepsy | ☐ Fainting |
| ☐ Glaucoma | ☐ Headaches | ☐ GERD |
| ☐ Heart murmur | ☐ Gout | ☐ Coronary Artery Disease |
| ☐ Hemophilia | ☐ Hepatitis | ☐ High Cholesterol |
| ☐ High blood pressure | ☐ Kidney disease | ☐ Liver disease |
| ☐ Macular Degeneration | ☐ Neuropathy | ☐ Pacemaker |
| ☐ Respiratory disease | ☐ Stroke | ☐ Swelling of feet or ankles |
| ☐ Thyroid problems | ☐ Ulcer | |

7. List medications you are currently taking

	Medication	Dosage	Frequency
1			
2			
3			
4			

8. Please list any allergies you may have:

	Allergy
1	
2	
3	
4	

9. Name and Location of Pharmacy

10. Social History

Smoking

Alcohol

Recreational drugs

Any Falls in the past 6 months? If so, any injures?

Did you take the Pneumonia Vaccine since your 60th birthday?

Did You Take The COVID-19 Vaccine in the Past Year

Do you have a Health Care Proxy?

Do you have a DNR/DNI?

11. Reason for today's visit:

12. Where is the pain/problem located?

	When did the pain begin?

Duration of Pain

Did you pain or problem:

☐ Began all of a sudden ☐ Gradually develop over time

How would you describe your pain

☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Sore ☐ Tingling
☐ Cramping ☐ Shooting ☐ Throbbing ☐ Unsure

How would you rate your pain on a scale of 0 to 10 (0 is no pain 10 is the worst pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Since the time your pain or problem began, has it:

☐ Stayed the same ☐ Became worse ☐ Improved

What makes your pain or problem better? Check all that apply:

☐ Heat ☐ Cold ☐ Change in weather ☐ Walking ☐ Standing ☐ Movement ☐ Resting ☐ Nothing

What makes your pain or problem feel worse? Check all that apply:

☐ Heat ☐ Cold ☐ Change in weather ☐ Walking ☐ Standing ☐ Movement ☐ Resting ☐ Dress Shoes
☐ Closed Toe Shoes ☐ Running

When is pain the worst? (Choose one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Constant ☐ After Activity

What treatments have you had for this problem?

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Signature

Date