176 Falls Ave Ste 200
Twin Falls, ID 83301
208-731-6321

ADVANCED FOOT & ANKLE

1263 Bennet Ave
Burley, ID 83318
208-312-4646

Advanced Foot & Ankle Mission Statement

At Advanced Foot & Ankle we are committed to getting you back on your feet free of pain and injury so that you can get back to your activities and back into life! We understand that when your feet hurt you hurt all over and you stop doing the things you love to do. We help stop the pain and prevent the injuries that occur in people's feet, ankles, legs, knees, hips and backs by addressing the imbalances which most often begin in the feet! We feel your feet are your foundation and a strong foundation is our goal. We thank you for the opportunity to serve you and give you the results you are looking for.

☐ Mr. ☐ Mrs ☐ Miss Today's Date: _____

_____ _____
Last Name First Name MI. Preferred Name

Email Address: _____

Age: _____ Birthday: _____ Home Phone #: (_____)_____ Cell Phone #: (____)_____

Local Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Sex: M / F Marital Status: S M W D

Other Address (if any): _____ Phone: (_____) _____

Occupation: _____ If retired, your former occupation: _____

Patient's Employer: _____ Business Phone: (_____) _____

Spouse: _____ Are they our patient? Yes / No

Are any of your friends, relatives or associates our patient? Yes / No If Yes, who? _____

If under 18 y/o, name of parent/guardian: _____ Relationship to Patient: _____

Responsible party's DOB: _____- _____ - _____ Responsible's party SS#: _____ - _____ - _____

In case of emergency, notify: _____ Relationship: _____

Home Phone: (___) _____ Business Phone: (___) _____ Other: (___) _____

Whom may we thank for your referral? _____

How did you hear about our practice? _____

If you used the internet to find us what search terms were used? _____

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Patient Name: _____

Primary Physician: _____ Date of last visit: _____

Other Physician: _____ Date of last visit: _____

Other Physician: _____ Date of last visit: _____

Medical History

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

Please list all current medications including dosage if known (or provide a copy of medication list):

_____

_____

Please list any allergies you have to medicines, adhesive tape, latex or foods.

_____

Do you have now, or have you ever had any of the following (please check all that apply):

- ○ Anemia
- ○ Asthma
- ○ Atrial fibrillation
- ○ Bladder infection
- ○ Blood disease/clots
- ○ Cancer: _____
- ○ Cellulitis
- ○ Chest pain
- ○ Congestive heart failure
- ○ COPD/emphysema
- ○ Coronary artery disease
- ○ Depression/anxiety
- ○ Diabetes
- ○ Dialysis
- ○ Epilepsy
- ○ Fractures
- ○ Glaucoma
- ○ Gout
- ○ Heart attack
- ○ Heart arrhythmia
- ○ Heart valve disease
- ○ Hiatal hernia
- ○ High blood pressure
- ○ High cholesterol
- ○ HIV
- ○ Kidney disease
- ○ Kidney stones
- ○ Liver problems
- ○ Numbness in feet or legs
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Pancreatitis
- ○ Reynaud's disease
- ○ Rheumatoid arthritis
- ○ Sinus problems
- ○ Sleep apnea
- ○ Stomach ulcer
- ○ Stroke
- ○ Thyroid disorders

Other conditions not listed above: _____

Family History: Please list diseases or illnesses of your immediate family (parents, grandparents, siblings): _____

Surgical history: Please list any surgeries you have had:

_____

_____

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REVIEW OF CURRENT SYMPTOMS:

(Please check all that apply)

General
- ○ Fatigue/exercise intolerance
- ○ Weight loss
- ○ Weakness

Head/ears/nose/throat
- ○ Ears (see ache/vertigo)
- ○ Headache
- ○ Hoarseness
- ○ Swallowing difficulties

Gastrointestinal
- ○ Appetite change
- ○ Abdominal pain
- ○ Indigestion
- ○ Nausea, vomiting
- ○ Diarrhea
- ○ Heartburn

Eyes
- ○ Vision problems/glasses
- ○ Cataract/glaucoma

Cardiovascular
- ○ Abnormal heart rate
- ○ Heart murmur
- ○ Ankle/leg swelling
- ○ Varicose veins
- ○ Use of blood thinner

Neurologic
- ○ Numbness/tingling
- ○ Weakness/paralysis

Genitourinary
- ○ Lack of bladder control
- ○ Painful urination/burning

Skin
- ○ Rash or irritation
- ○ Open sores
- ○ Nail changes

Pulmonary
- ○ Cough
- ○ Shortness of breath

SOCIAL HISTORY:

Do use smoke? Y N If yes: Packs per day _____ For how many years?_____

Drink alcohol? Y N What type? _____ How often? _____ How much? _____

Recreational drugs? Y N What type? _____ How often? _____ How long? _____

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1. **Do you have any FOOT/ANKLE pain?** ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both
   If yes, please explain: _____
   _____
   For how long? _____
   What previous treatments have been done for this pain / problem?
   Please explain: _____
   _____
   Does anything make it ☐ better or ☐ worse? _____
   _____

2. **Do you have any KNEE pain?** ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both
   If yes, please explain: _____
   _____
   For how long? _____
   What previous treatments have been done for this pain / problem?
   Please explain: _____
   _____
   Does anything make it ☐ better or ☐ worse? _____
   _____

3. **Do you have any HIP pain?** ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both
   If yes, please explain: _____
   _____
   For how long? _____
   What previous treatments have been done for this pain / problem?
   Please explain: _____
   _____
   Does anything make it ☐ better or ☐ worse? _____
   _____

4. **Do you have any Back pain?** ☐ Yes ☐ No ☐ Upper Back ☐ Lower Back ☐Neck
   If yes, Please explain: _____
   _____
   For how long? _____
   Previous treatment for this problem? _____ ☐ Yes ☐ No
   If yes, Please explain: _____
   _____
   Does anything make it ☐ better or ☐ worse? _____
   _____

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5. Do you have any leg cramps or pain? ☐ Yes ☐ No / ☐ Right ☐ Left ☐ Both

If yes, Please explain: (include Frequency)_____

_____

_____

How long has this been going on? _____

Previous treatment for this problem?_____ ☐ Yes ☐ No

If yes, Please explain: _____

_____

Does anything make it ☐ better or ☐ worse?_____

_____

6. Do any of the above problems limit your ability

to walk? ☐ Yes ☐ No _____

_____

to stand? ☐ Yes ☐ No _____

_____

to wear shoes? ☐ Yes ☐ No _____

_____

to work? ☐ Yes ☐ No _____

_____

to partake in social or sporting activities? ☐ Yes ☐ No _____

7. Do you currently wear or have you ever worn Orthotics (arch supports)? ☐ Yes ☐ No

If yes, were they prescribed to you by a physician or health care provider ☐ Yes ☐ No

If yes, were they the over the counter style bought from a store ☐ Yes ☐ No

If yes, did you find that they helped you to any significant degree ☐ Yes ☐ No

8. If you are a runner or athlete please tell us about your sport. Include recent history, weekly mileage breakdown, frequency or times and if you are currently training for any event.

_____

_____

_____

9. What type of Shoes do you wear and how often do you wear them? Please Circle or cross out

MALE

☐ Sneakers / Tennis Shoes _____ % of time
☐ Lace Up Dress Shoes _____ % of time
☐ Loafers or Deck Shoes _____ % of time
☐ Work Boots or Other Boots _____ % of time
☐ Flip Flops or Sandals _____ % of time

FEMALE

☐ Sneakers / Tennis Shoes _____ % of time
☐ Casual Shoes _____ % of time
☐ Pumps or Low Heel Open Shoes _____ % of time
☐ High Heel Shoes (2 inch or greater) _____ % of time
☐ Work Boots or Other Boots _____ % of time
☐ Flip Flops or Sandals _____ % of time

10. When you're at home, what is on your feet?

☐ Regular Shoes _____ % of time ☐ Slippers _____ % of time ☐ Bare Feet _____ % of time

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This is the most important part of this paper work.

11. In the last few months has there been a recent change in your:

☐ Weight ☐ Work ☐ Activity ☐ Shoe Gear ☐ Flooring at work or home

Please explain: _____

_____

Please tell us what are your Goals and Expectations are relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your visit today?**

_____

_____

_____

_____

Relating to your specific complaint(s), what would you like to be able to accomplish **in the near future** that you may not be able to do right at this moment? **(Please include intermediate and long term goals)** _____

_____

_____

_____

I understand that any follow-up appointments I make are crucial to my treatment and the success of my care. During these appointments, the doctor will give you the necessary attention. Please have the courtesy of keeping all appointments or calling to change an appointment with 24 hours notice.

I understand that I will be charged a fee of $40.00 for any appointments missed with less then 24 hours cancellation notice.

Patient/ Guardian Print: _____ Date: _____

Patient/ Guardian Signature:_____ Date: _____

Thank you very much for filling out our New Patient paper work. Please return the forms to the receptionist when you come in along with your insurance card (if applicable) and your photo ID.

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Insurance Information / Consent / Authorization

Please bring your insurance cards and a photo ID to the front desk so we may make photocopies.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediary or carriers, or to the billing agent of Advanced Foot & Ankle, any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of my medical records to and /or from my physician or other health care providers.

I understand that payment is due at the time of service unless other arrangements have been made I also understand that when payment becomes my responsibility after 60 days, I may be charged an interest rate of 18% or 1.5% of the outstanding balance.

Patient / Guardian Print: _____ Date: _____

Patient / Guardian Signature: _____ Date: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to: Advanced Foot & Ankle for any service furnished me by the physician.

Patient / Responsible Party Print: _____ Date: _____

Patient / Responsible Party Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the Notice of Privacy Practices and that I have read, had the opportunity to read, or plan to take it home to review. It is my understanding that if I have a question, I may contact the privacy officer at Advanced Foot & Ankle.

_____ _____
Patient Name (please print) Date

_____
Parent or Guardian (if applicable) (please print)

_____
Signature