

**Practice of**  
**Louis R. MacDonald, DPM; B Thomas Kempf, DPM; Meenakshi Singhal, DPM;**  
**Alex Mand, DPM; Sean Lynch, DPM; Duan Zhang, DPM**

<b>Today's Date:</b> _____	
<b>Name:</b> _____	<b>DOB:</b> _____ <b>SSN:</b> _____
<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
<b>Spouse/Partner Name:</b> _____	
<b>E-Mail:</b> _____	
<b>CellPhone #:</b> _____	<b>Home Phone #:</b> _____ <b>Other:</b> _____
<b>Address:</b> _____	<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>Emergency Contact Name:</b> _____ <b>Phone:</b> _____	
<b>Employer:</b> _____	<b>Employer Phone Number:</b> _____
<b>Employer Address:</b> _____	<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____

<b>Primary Insurance:</b> _____	<b>Are you the insured?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Subscriber Name:</b> _____	<b>Relationship to insured:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
<b>Subscriber Phone #:</b> _____	<b>DOB:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Subscriber Address:</b> _____	
<b>Policy ID:</b> _____	<b>Group ID:</b> _____ <b>Employer:</b> _____
<b>Secondary Insurance:</b> _____	<b>Are you the insured?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Subscriber Name:</b> _____	<b>Relationship to insured:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
<b>Subscriber Phone #:</b> _____	<b>DOB:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Subscriber Address:</b> _____	
<b>Policy ID:</b> _____	<b>Group ID:</b> _____ <b>Employer:</b> _____

<b>How did you hear of our office?</b> <input type="checkbox"/> Physician <input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Insurance
<input type="checkbox"/> Other Internet: _____ <input type="checkbox"/> Other: _____

**PLEASE READ AND SIGN:** The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits and Acknowledgements): I authorize payment of medical benefits to the practice named above. I authorize the release of any medical information necessary to process claims. I certify I will pay to the practice co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay to the practice any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing or fail to secure the appropriate referrals. (Method of contact): I agree that the practice named above, its affiliates, and those acting on its behalf, may call, text or email me. They may use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medical Records): I authorize the release of my medical records from prior and concurrent physicians, podiatrist, and other health professionals to the above doctors. (Medication History): I authorize the Doctor's office to retrieve my medication history.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Medical History:**

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> COPD             | <input type="checkbox"/> Stroke            | <input type="checkbox"/> HIV              |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Blood clot        | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Blood disorders   | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> A Fib                | <input type="checkbox"/> Sleep apnea      | <input type="checkbox"/> GERD              | <input type="checkbox"/> Mental illness   |
| <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> High cholesterol     | <input type="checkbox"/> Breathing issues | <input type="checkbox"/> Stomach ulcer     | <input type="checkbox"/> Dementia         |
| <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Gout             | <input type="checkbox"/> Bowel obstruction | <input type="checkbox"/> Sciatica         |
| <input type="checkbox"/> On Dialysis     | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Skin disorders   | <input type="checkbox"/> IBS               | <input type="checkbox"/> Lyme's Disease   |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Psoriasis        | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> COVID 19         |
- Neuropathy (Specify) \_\_\_\_\_  Cancer \_\_\_\_\_
- Arthritis (Specify) \_\_\_\_\_
- other: \_\_\_\_\_

**Current Medications**

- No Medications  See attached list
- I take the following medications
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_
- Name: \_\_\_\_\_
- Use the back of this form if more room is needed

**Allergies**

- No Known Allergies  No Known Drug Allergies
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Name: \_\_\_\_\_ Reaction: \_\_\_\_\_
- Use the back of this form if more room is needed

**Pharmacy** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Smoking Status:**

- Current Every Day  Smoker, Current status unknown  Unknown if ever  Never
- Current Some Day  Heavy Tobacco  Light tobacco  Former

**Do you drink alcohol?**  Yes, everyday (5-7days/week)  Yes, socially/occasionally  No/Rarely

**Have you ever had a substance abuse problem?** Please specify: \_\_\_\_\_

**Last Flu Shot Date:** \_\_\_\_\_ **Pneumonia vaccine?**  Yes  No

**Do you have any advanced directives?**  No  Living will  Power of Attorney  Do Not Resuscitate

Surrogate Decision Maker: \_\_\_\_\_

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Date: \_\_\_\_\_

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**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**What is the reason for your appointment today?** \_\_\_\_\_

**Result of accident or work injury?**  Yes  No

**How long has this bothered you?** \_\_\_\_\_

**What treatments have you tried & have they been effective?** \_\_\_\_\_

**On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain?** \_\_\_\_\_/10

**The pain quality is:**  burning  throbbing  constant  dull  sharp  shooting  tingling  other: \_\_\_\_\_

**What shoe size do you wear?** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Endocrinologist:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Cardiologist:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Vascular Surgeon:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Review of Systems**

<b>Cardiovascular</b>	<input type="checkbox"/> fever <input type="checkbox"/> leg swelling	<input type="checkbox"/> chest pain / pressure <input type="checkbox"/> leg pain when walking	<input type="checkbox"/> cold hands/feet <input type="checkbox"/> fainting	<input type="checkbox"/> palpitations <input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems <input type="checkbox"/> NONE
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine <input type="checkbox"/> hesitancy	<input type="checkbox"/> decreased frequency <input type="checkbox"/> increased urgency	<input type="checkbox"/> incontinence	<input type="checkbox"/> excessive urination <input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones <input type="checkbox"/> NONE
<b>Gastrointestinal</b>	<input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea	<input type="checkbox"/> heartburn <input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> blood in stool <input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers <input type="checkbox"/> decrease appetite	<input type="checkbox"/> constipation <input type="checkbox"/> NONE
<b>Integumentary</b>	<input type="checkbox"/> athletes foot	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> NONE
<b>Hematologic</b>	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> NONE
<b>Neurological</b>	<input type="checkbox"/> tingling <input type="checkbox"/> tremors	<input type="checkbox"/> weakness <input type="checkbox"/> paralysis	<input type="checkbox"/> seizures <input type="checkbox"/> numbness	<input type="checkbox"/> headaches	<input type="checkbox"/> NONE
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain <input type="checkbox"/> sciatica	<input type="checkbox"/> joint swelling <input type="checkbox"/> joint stiffness	<input type="checkbox"/> muscle weakness <input type="checkbox"/> muscle pain	<input type="checkbox"/> arthritis <input type="checkbox"/> neck pain	<input type="checkbox"/> joint pain <input type="checkbox"/> NONE
<b>Respiratory</b>	<input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath	<input type="checkbox"/> wheezing <input type="checkbox"/> emphysema	<input type="checkbox"/> COPD <input type="checkbox"/> coughing	<input type="checkbox"/> snoring	<input type="checkbox"/> NONE

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