Phone (509) 590-2306
Fax (509) 483-8338
203 E. Dalke, Suite B.
Spokane, WA. 99208

New Patient Information

PLEASE COMPLETE FORM USING A PEN.

Last name________________________________ **First Name** _____________________________**M.I.**________

Address____**City**_______________**Zip**______________

Home Phone________________________________ **Cell Phone**_____________________________________

Birthdate ___/___/___. **Email**____

Occupation_____________________________**Employer**____

Employer's Address____

City/State ____________________________**Zip** ______________**Work phone** _________________________

Emergency Contact Name________________________ **phone** ______________**Relationship** ____________

HOW DID YOU HEAR ABOUT OUR CLINIC? ____

____

**** Please provider Insurance cards upon arrival to copy to your chart.**

****Medication Lists may be copied for your convenience.**

**** Allergies:** List anything you are allergic to (medications, food, bee stings etc.) and how it affects you.

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____

****Favorite Pharmacy**:____

Medications: Please list all the medications you are taking including prescribed, over the counter and supplements. Make sure to include strength and how often it's taken. You may skip this step if you have provided a copy to the receptionist.

1.______________________________________ 2.____

3. ______________________________________ 4.____

5. ______________________________________ 6. ____

7. ______________________________________ 8.____

9. _____________________________________ 10.____

11. ____________________________________ 12. ____

13. ____________________________________ 14.____

15.____________________________________ 16.____

17. ____________________________________ 18. ____

Please continue with the health questionnaire so we may properly assist you today.

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.

What is the Reason for your visit today?

____

____

Tell us about any of these symptoms that you have in your feet or legs

Mark any that apply

○ Numbness	○ leg cramps
○ tingling	○ difficulty sleeping from leg and foot pain
○ pins and needles sensation	○ diminished sensation of heat or cold
○ foot pain with walking or weight bearing	○ sensation of bugs crawling on your feet

Past Medical History: Circle any of the following that apply to you.

Anxiety disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Auto-Immune disorders	Heart Attack	Liver Disease
Bleeding Disorder	Has Pacemaker	Osteoporosis
Blood Clots	Heart Stents	Pacemaker
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes-Insulin	High Cholesterol	Stroke
Diabetes- Non insulin	High Blood Pressure	Tuberculosis
Dialysis	Over/Under Active Thyroid	Other
Other	Other	Other

Past Surgical History (Please include year, reason and what hospital and/or Doctor if you are able):

____

____

____

Family History: Your family history is an important part of learning about you. Please place a check in the boxes appropriate for your family history for any conditions that you are aware of and if they are still alive.

Relationship	Grand-mother (M)	Grand-father (M)	Grand-mother (P)	Grand-father (P)	Mother	Father	Brother	Brother	Sister	Sister	Other
-_Alive?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
----------Age											
Conditions											
Alcoholism											
Arthritis											
Depression											
Cancer											
Diabetes											
Heart Disease											
Hypertension											
Osteoporosis											
Stroke											
Other											

Social History: Circle the following that apply to you.

Education	Marital Status	Exercise	Caffeine
○ < 8th grade ○ High School ○ 2 Yr College ○ 4 Yr College ○ Post Graduate	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner	○ No Exercise ○ Occasional exercise ○ Moderate exercise ○ High Level exercise	○ None ○ 1 cup per day ○ 2 cups per day ○ 3 cups per day ___# of cups per day?

Alcohol	Tobacco	Drugs
Drink alcohol? **Y/N** ---If yes, What kind? ----Beer Y/N ----Wine Y/N ----Hard alcohol Y/N How many drinks per day? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 # Drinks/week? ______	Do you use tobacco? **Y/N** **If no,** did you ever use tobacco? **Y/N** ○ Cigarettes___ pks/day ○ Chew___/day ○ Cigars___/day Number of Years used ____________ ----**OR** year started__________ And year quit ___________	Do you currently *use recreational* or street drugs? **Y/N** If yes, please check all that apply. Or write it any not listed. ○ Marijuana ○ Methamphetamine ○ Amphetamine ○ Cocaine ○ Heroin ○ Opiates

Additional Health Facts (please list other information about your health you would like your provider to know): ____

____

____

____

____

___________________________________ ____

Parent, Guardian or Caregiver signature Date

Review of Systems

Please indicate any of these symptoms you have

Constitutional
- Chills
- fatigue
- Fever
- Night sweats
- Weight gain
- Weight loss
-

Eyes
- Blurry vision
- Dry eyes
- Changes in vision
- Eye pain

Date of last exam________

Ear, Nose, Throat, Mouth
- Change in sense of smell
- Dry mouth
- Ear pain or pressure
- Hearing loss
- Neck pain or stiffness
- Oral pain
- Nasal congestion
- Post nasal drip
- Sinus pressure/pain
- Tinnitus/ringing of ears
- Sore throat
- Difficulty swallowing

Cardiovascular
- Chest pain/pressure at rest
- Chest pain/pressure with exertion
- Shortness of breath with exertion
- Claudication
- Cold hands or feet
- Exercise intolerance
- Palpitations
- Syncope/Fainting
- Near fainting

Respiratory
- Shortness of breath with exertion
- Shortness of breath at rest
- Coughing up blood
- Pain with inspiration
- Productive cough
- Wheezing
- Sleep apnea

Gastrointestinal
- Abdominal pain
- Constipation
- Diarrhea
- Difficulty swallowing
- Fecal incontinence
- Blood in stool
- Vomiting
- Vomiting blood
- Black stool
- Trouble swallowing

Genitourinary
- Blood in urine
- Discharge
- Pain with urination
- Difficulty urinating
- Urinary frequency
- Loss of urinary control

Musculoskeletal
- Fractures
- Back pain
- Joint pain
- Joint instability
- Muscle aches
- Muscle weakness
- Falls
- Balance problems
- Use of assistive device

Skin
- Changes in moles
- Dry skin
- Itching
- Growths or lesions
- Rash
- Yellowing of skin

Neurological
- Coordination problems
- Dizziness
- Fainting
- Headaches
- Memory loss
- Migraines
- Numbness
- Seizures
- Speech problems
- Weakness
- Restless legs
- Tingling

Psychiatric
- Alcohol over use
- Anxiety/stress
- Depression
- Sleep problems

Endocrine
- Increased thirst
- Change in hair growth
- Heat or cold intolerance
- Goiter/lump in neck

Lymphatic
- Bleeding tendency
- Lymph node pain/enlargement
- Transfusions

Allergic/Immunologic
- Frequent sneezing
- Eye discharge
- Sinus pressure
- Sinus congestion
- Runny nose
- Hives