

DR. ALFORD'S & DR. WERNER'S NEW PATIENT FORM

NAME _____ CHIEF COMPLAINT _____ REF SOURCE _____

AGE _____ HEIGHT _____ WEIGHT _____ ALLERGIES _____

HISTORY: SYMPTOMS:

DURATION _____ (Days, Weeks, Months, Years)

WHERE: ANKLE _____ LEG _____ FOOT _____ ARCH _____ HEEL _____ BALL of FOOT _____ TOES _____

RESULT OF INJURY: YES _____ NO _____

WORK RELATED: YES _____ NO _____

PAIN WORSE WITH: STANDING _____ WALKING _____ AT REST _____ NIGHT _____ AFTER REST _____

PRIOR TREATMENT: _____ MEDICINE (Advil, Motrin, Etc.)
_____ ORTHOTICS
_____ SHOE MODIFICATIONS
_____ THERAPY OR EXERCISES
_____ SURGERY, if so, DESCRIBE:
_____ X-RAY, MRI, BONE SCAN, ARTERIOGRAM

MEDICAL HISTORY: _____ HIGH BLOOD PRESSURE
_____ DIABETES
_____ HEART DISEASE
_____ VASCULAR DISEASE
_____ NEUROPATHY
_____ CANCER
_____ STOMACH
_____ RHEUMATOID ARTHRITIS
_____ OTHER

MEDICATIONS: 1)
2)
3)
4)
5)
6)
7)
8)
9)

SURGICAL HISTORY: 1)
2)
3)
4)
5)

FAMILY HISTORY: _____ HIGH BLOOD PRESSURE
_____ DIABETES
_____ HEART DISEASE
_____ VASCULAR DISEASE
_____ NEUROPATHY
_____ RHEUMATOID ARTHRITIS
_____ CANCER
_____ OTHER

SOCIAL HISTORY: EMPLOYER:
POSITION:
FAMILY:
HABITS: ALCOHOL _____ TOBACCO _____

SYSTEMS REVIEW: _____ FEVERS or CHILLS
_____ NUMBNESS or TINGLING
_____ SWELLING
_____ OTHER JOINT or MUSCLES
_____ LYMPH NODES

PHYSICAL EXAM: _____ RIGHT _____ LEFT

CONSTITUTIONAL:
CV:
SKIN:

NEUROLOGIC: GAIT:
SENSATION:
REFLEXES:

MUSCULOSKELETAL: SPINE:
ALIGNMENT:
ROM:
STRENGTH:
STABILITY:

LYMPHATIC: