

Katherine E. Chou, DPM

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New Patient Intake Form

Patient Name: _____ **DOB:** ____ / ____ / ____

Nickname, Chosen name, etc.: _____ **SSN:** ____ - ____ - ____ (For insurance verification)

Sex: ☐ Male ☐ Female **Pronouns:** ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email address: _____

Phone Number: *Appointment reminders will be sent to 1st number listed.*

☐ Cell ☐ Home ☐ Work: (_____) _____ Texts/Confidential Message OK? ☐ Yes ☐ No

☐ Cell ☐ Home ☐ Work: (_____) _____ Texts/Confidential Message OK? ☐ Yes ☐ No

Ethnic Group (Select One):

- ☐ Latino/Latina/Hispanic
- ☐ Non-Hispanic or Latino/a
- ☐ Declined/Unknown
- ☐ White

Race: (Select all that apply)

- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other/Unknown/Declined

Marital Status: ☐ Single ☐ Married ☐ Significant other ☐ Widowed

Employment Status (Check one): ☐ Full Time ☐ Part Time ☐ Retired ☐ Self-Employed

Occupation: _____

Employer: _____

Primary Language: _____

Primary Care Provider (PCP): _____

Referral Source: ☐ PCP ☐ Yelp ☐ Apple Wellness Center ☐ Prior patient ☐ Google
☐ Other: _____

Family History:

Do you have a family history of any of the following?

Key: M-mother F-father, Si-sister, B-brother, D-daughter, So- Son

Diabetes: ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

Heart attack: ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

High Cholesterol: ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

High Blood Pressure: ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

Stroke: ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

Cancer, type? _____ ☐ M ☐ F ☐ Si ☐ B ☐ D ☐ So

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☐ High Blood Pressure ☐ Gout
☐ Scoliosis ☐ Arthritis
☐ Asthma ☐ Foot ulcers
☐ High Cholesterol ☐ Diabetes Mellitus
☐ Kidney Disease ☐ Heart Disease
☐ Thyroid Disease ☐ Foot Fracture or Surgery
☐ Osteoporosis ☐ Numbness in feet/legs
☐ Peripheral Vascular Disease (PVD)
☐ Cancer, Type: _____

☐ Appendectomy ☐ C-Section
☐ Ankle Surgery ☐ Foot Surgery
☐ Hysterectomy ☐ Valve Replacement
☐ Tonsillectomy ☐ Heart Surgery
☐ Orthopedic Surgery
☐ Other: _____

Packs/Day: _____ Years: _____

List all medications, vitamins, or other supplements you are taking.

[illegible]

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In the last few months has there been any recent changes in your:

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

Please explain: _____

Please tell us what 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)** _____

OFFICE POLICIES

I acknowledge I was provided a copy of the **HIPPA Privacy Policy** and I have read and understand the notice. I acknowledge I was provided a copy of the **Office Financial Policy** and I have read and understand the notice. I agree to abide by all these policies.

Signature of patient

(or financially responsible party)

Relationship

Date

*The typed name is acceptable as an electronic signature