Welcome to Angel Foot Care Wellness

Nurse owned & Operated offering Mobile Foot Wellness Treatment

Phone: (323-201-7311)
info@angelcarefootwellness.com

Please Complete the three forms and email them back to us at info@angelcarefootwellness.com

Last Name _____ First Name _____ Initial _____

Name You Go By _____ Age _____ Date of Birth _____/_____/____ Sex: M F

Street_____ City_____ State _____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Social Security # _____Driver's License # _____ Marital Status: M S W D

Employer _____ Occupation _____

Street_____ City_____ State _____ Zip _____

Emergency Contact_____ Relationship _____

Referring Information

Who may we thank for referring you? _____

Family Doctor:_____Current Client:_____

What is your chief foot complaint? _____

I understand I will be charged $100 if I fail to show up for my appointment or cancel my appointment within 24 hours.

Signature: _____

Email: _____ Date:_____

Your email address will never be shared without your permission but will be used for communication from the office

ANGEL CARE
Foot Wellness

Medical History

What is your foot problem?

_____

_____

When did problem begin? _____ Date (if an injury): _____

Describe any accident/event _____

Previous X-rays? Yes No Previous MRI? Yes No Previous CT? Yes No

Describe any previous treatment or home remedies _____

Have you ever had foot surgery? Yes When and by whom? _____

Are you here for a: Consultation

Do you have or have you ever been treated for:

Diabetes I or II	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Poor Circulation	Yes	No
Problems Healing	Yes	No
Kidney Disease	Yes	No
Asthma	Yes	No
Autoimmune Disease	Yes	No
Sleep Apnea	Yes	No
Hepatitis	Yes	No
HIV	Yes	No

List other health problems: _____

_____

_____

_____

Height: _____ Weight: _____

How much are you on your feet at work?

20% 40% 60% 80% 100%

Do you smoke? Yes packs per day ____ No

Do you drink alcoholic beverages?

None Rarely Moderately Daily Quit

List any sports/activities: _____

Allergies to Medications or Materials:

Antibiotics (please list below)	Yes	No
Pain Medication (Codeine, Vicodin)	Yes	No
Local anesthetics	Yes	No
Adhesive tape	Yes	No
Latex	Yes	No
Iodine	Yes	No

Type of reaction: _____

_____

Any Other Allergies: _____

_____

Do you take any of the following medications?

	Yes	No	Medication
Insulin			_____
Oral diabetic medication			_____
Blood thinner			_____
Heart medication			_____
Water pills			_____
Birth control pills			_____
Anti-depressant			_____

Please list other medications: _____

_____

_____

_____

Please list previous medical or surgical problems: _____

_____

If female, are you pregnant? Yes No

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Privacy Practices and Consent

The Health Insurance Portability & Accountability Act of 1996 requires that all medical records and other individually identifiable health information used or disclosed by this office be kept properly confidential. The individual is also provided the right to request confidential communications or that a communication of protected health information (PHI) be made by alternative means.

I wish to be contacted in the following manner (circle all that apply):

1. Home Telephone _____
    a. OK to leave message with spouse
    b. OK to leave message with detailed information
    c. Leave message to call the office only
2. Work Telephone_____
    a. OK to leave message with detailed information
    b. Leave message to call the office only
3. Written Communication
    a. OK to mail to my home address
    b. OK to mail to my work or office address
    c. OK to fax to this number _____
    d. OK to exchange information with referring doctors and treatment facilities
4. Other _____

_____ _____
Patient or Guardian Signature Date

_____ _____
Print Name Birth Date

I authorize your office to disclose my health information to the following people if needed

1. _____

2. _____