Schussler FOOT CARE Centers

Welcome To Our Practice

As a new patient, please fill out the information found below to the best of your ability. This will aid us in understanding your health prior to any treatment. Thank You.

Patient's Name: _____ Age: _____ Birthdate: _____
Last First M.I.

Family Physician: _____ Last Date Seen: _____

HISTORY OF PRESENT ILLNESS

Chief Complaint: _____

_____

When did it start? _____ Cause of the disease: _____

Where does it hurt? _____

Aggravating Factors: _____

Any previous treatments or tests and by whom? _____

Has this same condition occurred in the past? _____

PAST MEDICAL HISTORY

Previous Hospitilizations/Surgeries/Serious Illnesses

	Date		Date
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

SOCIAL HISTORY

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Use of Alcohol ☐ never ☐ rarely ☐ moderate ☐ daily Have you been treated for alcoholism? _____

Use of Tobacco: ☐ Never ☐ Smokes how many packs per day? _____
For how many years? _____
☐ Quit Smoking: How long ago? _____ How much did you smoke? _____
How many years? _____

Use of "illicit" or "recreational" drugs: ☐ Never ☐ Type/frequency _____

Use of Caffeine: ☐ Never ☐ How many cups

FAMILY HISTORY

	Age	Diseases	if deceased, cause of death
Father:			
Mother:			
Siblings:			

Patient Signature _____ Date _____