



Welcome to Our Practice



Name _____ **Social Security #** _____ **Birthdate** _____
 Last First M.I.

Gender M F **Home Phone** _____ **Alt. Phone** _____ **Occupation** _____
 (please circle)

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

E-Mail _____ **Whom may we thank for referring you?** _____

SPOUSE _____ **Status** Married Divorced Widowed Single Life Partner Minor
 Last First M.I. (please circle)

Primary Insurance Information

Plan Name _____ **Policy #** _____ **Group #** _____

Are you the policy holder? Yes No **If "No"** Policy Holders Name _____ **DOB** _____

Secondary Insurance Information

Plan Name _____ **Policy #** _____ **Group #** _____

Are you the policy holder? Yes No **If "No"** Policy Holders Name _____ **DOB** _____

Insurance Assignment and Releases

I certify that I have coverage with the above listed insurances and assign Directly to Dr. David S. Jenson, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and my disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed.

I, the above patient, acknowledge that I have been able to view the NOTICE OF PRIVACY PRACTICES. I have have alos been given the opporrtunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice, others or myself.

In Case of Emergency

Name _____ **Relationship** _____ **Phone** _____

Podiatric History

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints)

Y N

Y N

Y N

Y N

Please indicate which foot problems you now have or have had in the past.

- Y N Ankle Pain
 Y N Athlete's Foot
 Y N Bunions
 Y N Corns and Calluses
 Y N Cramps or Numbness in Feet or Legs
 Y N Flat Feet
 Y N Foot or Leg Cramps
 Y N Heel Pain
 Y N Ingrown Toenails
 Y N Plantar Warts
 Y N Swelling of Ankles or Feet
 Y N Tired Feet

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Social History

- Y N Tobacco Use
 Y N Alcohol Use
 Y N Drug Use
 Y N Caffeine Use
 Y N Good Exercise Habits

Y N

Y N

Y N

Y N

Y N

Y N

Are you Diabetic?

YES Type _____ **No**

Y N

Y N

Y N

- Anemia
 Anesthetic Reaction
 Arthritis
 Asthma
 Bleeding Disorders
 Cancer
 Circulation Problems
 Stroke
 Epilepsy
 Foot Problems
 Gout
 Heart Disease
 Hepatitis
 High Blood Pressure
 High Cholesterol
 HIV/AIDS
 Injury/Trauma - Major
 Kidney Disease
 Liver Disease
 Mitral Valve Porlapse
 Nail Disorders
 Nerve Disorders
 Obesity
 Phlebitis
 Pulmonary Disease
 STD
 Skin Problems

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient/guardian _____

Printed name _____

Please complete other side

CONSTITUTIONAL		MUSCULOSKELETAL		NEUROLOGICAL			
Are you feeling good?	YES NO	Do you have lower back pain?	YES NO	Do you get dizzy?	YES NO		
Do you feel fatigue during the day?	YES NO	Do you have pain in your legs?	YES NO	Do you get disoriented?	YES NO		
Is your foot problem relieved by ceasing daily activities?	YES NO	Do you have pain in your foot or feet?	YES NO	Do you have problems keeping your balance?	YES NO		
Do you have a fever?	YES NO	Do you have joint pain?	YES NO	Do you often get headaches?	YES NO		
EYES & EARS		Do you have bone pain?	YES NO	Do you have seizures?	YES NO		
Do you wear glasses or contacts?	YES NO	Do you have general muscle aches or pain?	YES NO	Do you get tremors?	YES NO		
Do you have eye pain?	YES NO	Have you had swelling in your legs?	YES NO	Do your legs feel like they are falling asleep often?	YES NO		
Do you have ringing in your ears?	YES NO	Have you had joint swelling?	YES NO	Do you have numbness in your legs?	YES NO		
CARDIOVASCULAR		Do you have joint stiffness?	YES NO	Do you have burning in your legs?	YES NO		
Do you have swelling of both legs?	YES NO	Have you noticed a change in the way you walk?	YES NO	Do you have cramping in your legs when walking?	YES NO		
Do you have varicose veins?	YES NO	Do you legs cause difficulty in climbing stairs?	YES NO	Do you have pain in your legs while at rest?	YES NO		
Do you have cramping in your legs at night or at rest?	YES NO	Are you experiencing any loss of strength in your legs?	YES NO	Do you have pain in your legs all the time?	YES NO		
Do you have cramping in your legs when walking?	YES NO	Have you felt rigidity in your legs?	YES NO	Do you have shooting pain in your lower extremities?	YES NO		
Do your feet feel especially cold?	YES NO	Do you limp when you walk?	YES NO	Do you have leg paralysis?	YES NO		
RESPIRATORY		Do your shoes wear out relatively quickly or unevenly?	YES NO	Do your shoes wear out relatively quickly or unevenly?	YES NO		
Do you have chest pain?	YES NO	INTEGUMENTARY		PSYCHIATRIC			
Do you have difficulty breathing?	YES NO	Do you have any skin problems?	YES NO	Do you have any psychiatric problems?	YES NO		
Do you have shortness of breath?	YES NO	Do you have sun sensitivity?	YES NO	Do you have mood swings?	YES NO		
GASTROINTESTINAL		Do you have any skin rashes?	YES NO	Are you under stress?	YES NO		
Do you have a loss/increase of appetite?	YES NO	Do you have any warts on your feet?	YES NO	ENDOCRINE			
Do you have stomach ulcers?	YES NO	Do you have any moles, lumps or bumps?	YES NO	Have you lost/gained weight over the last several months?	YES NO		
Do you have frequent heartburn?	YES NO	Do you have dry skin?	YES NO	Are you excessively thirsty?	YES NO		
Does aspirin cause your stomach problems?	YES NO	Do you have any open sores?	YES NO	Do you have bad breath?	YES NO		
Do you have bloody or dark stools?	YES NO	Do you have any skin discolorations?	YES NO	Do you have night sweats?	YES NO		
GENITOURINARY		Do you have calluses or corns?	YES NO	Do you have swollen glands?	YES NO		
Do you have frequent urination?	YES NO	Do you have thick nails?	YES NO				
Do you have pain with urination?	YES NO	Are your nails deformed?	YES NO	HEMATOLOGIC/LYMPHATIC			
Do you have burning with urination?	YES NO	Are your nails ingrown	YES NO	Do you bruise easily?	YES NO		
Have you noticed blood in your urine?	YES NO			ALLERGIC/IMMUNOLOGIC			
PLEASE LIST ALL PREVIOUS SURGERIES YOU HAVE HAD	PLEASE LIST ALL CURRENT MEDICATIONS YOU TAKE AND THEIR DOSAGE		If you get cut, does it take long to heal?			YES NO	
			Please list all allergies				

David S. Jenson, DPM, PA
 111 Vision Park Blvd Ste 240
 The Woodlands, TX 77384
 (P) 936.273.6000 – (F) 936.273.6022

Initial Pain Assessment Form
(Please fill out as much as possible)

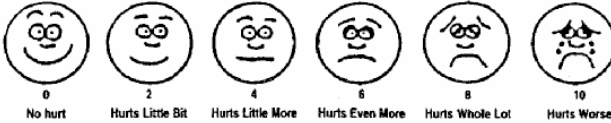
Name: _____ DOB: _____ WT: _____ HT: _____

Please list any medication Allergies _____

Primary Care Physician Name and phone number _____

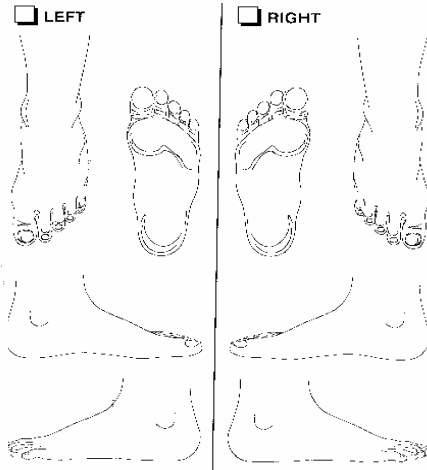
Date: _____

1. Which face shows how much you hurt now?
 Put an "X" on the face.



If you have no pain, stop here.
If you have pain, answer questions 2 through 12.

2. Where is your pain?
 Mark the areas on your body where you feel pain with "X"s.



3. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Other		

4. Circle one: Occasional Continuous

5. Circle the time of day your pain is the worst.
 (More than one time may be selected.)

Morning Afternoon
 Evening Nighttime

6. What makes your pain better? _____ 7. What makes your pain worse? _____

8. What treatment or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ Treatment or Medicine (include dose)	No Relief	0	1	2	3	4	5	6	7	8	10	Complete Relief
b) _____ Treatment or Medicine (include dose)	No Relief	0	1	2	3	4	5	6	7	8	10	Complete Relief

9. Does your pain make it harder for you to: (circle all that apply)
 Walk Sleep Sit Work Enjoy Life Eat Be Active Be with family or friends

10. What other problems are you having? (circle all that apply)
 Constipation Dry Mouth Sleepiness Nausea / Vomiting
 Other symptoms _____

11. What is your goal for pain control (pain intensity and goals related to activities / quality of life)?

12. Do you have any other comments to share with us regarding your pain?

David S. Jenson, DPM
111 Vision Park Blvd Ste 240
The Woodlands, Texas 77384

RELEASE OF MEDICAL RECORDS

(For Immediate family only)

Please Print

Patient Name: _____

Date: _____

DOB: _____

I, the above patient, give permission to the office of Dr. David S. Jenson, to provide any information regarding my medical records, including but not limited to, office notes, x-rays, lab results and billing information, to the following recipients:

Name Relationship

Name Relationship

Name Relationship

If there is no one you wish to receive your information please mark a line through this page.

To make any changes to your release, please submit your request in writing to our office.

Record requests may take up to 7- 10 business days to complete.

Please be aware this release is void 180 days after the date signed and you may be asked for your release in the future for any of the above noted information.

Patient Signature

Date

David S. Jenson, DPM
111 Vision Park Blvd
Suite 240
The Woodlands, TX 77384

Notice of Privacy Practices

Patient Name (please print): _____

I, the above patient, acknowledge that I have been able to view the Notice of Privacy Practices posted in the office of Dr. David S. Jenson. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice, others or myself.

Signature

Date

Dr. David Jenson, DPM, PA
111 Vision Park Blvd Ste 240
The Woodlands, TX 77384
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Fee Policy

Effective January 1, 2009:

All no shows and cancellations with less than a 24 hour notification will be subject to a \$25 fee which will be applied to your account and **MUST** be paid before your next visit.

Patient Signature