SOLE SANCTUARY
PODIATRY
Lorelei C. Achor, DPM, DABPM

NEW PATIENT INFORMATION

Comprehensive Patient Intake

Self Pay Care

We want to understand your health history, how you move, and what matters to you. Your answers will help us plan care around your needs and goals.

Complete what you can. Write “none,” “not sure,” or “prefer to discuss” where helpful. You may attach medication lists and additional pages. Ask for assistance if needed.

Getting to Know You

Legal name _____

Preferred name _____ Date of birth _____ Date _____

Pronouns optional _____ Occupation or daily role _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Preferred language _____ Interpreter needed [ ] Yes [ ] No

Emergency contact _____ Relationship _____

Emergency contact phone _____

Primary care clinician _____ Phone _____

Other clinicians involved in this concern _____

How did you hear about us _____

Your Priorities

What brings you here now? What is your most important concern?

_____

_____

What would you like your health and mobility to make possible in your life?

_____

_____

Do you need help with forms, hearing, vision, mobility, or communication?

_____

Contact details above do not authorize medical information to be sent by text or email. Communication preferences and permissions are documented separately.

PATIENT INTAKE

Your Current Concern

Patient name _____ Date of birth _____

Describe the problem in your own words. Where is it located?

_____

_____

Side [ ] Right [ ] Left [ ] Both [ ] Other _____ Start date _____

Onset [ ] Sudden [ ] Gradual [ ] After injury or surgery [ ] Unsure

Course [ ] Improving [ ] Worsening [ ] Unchanged [ ] Comes and goes

What was happening when it began? Was there an injury, illness, or change in activity?

_____

_____

Symptoms [ ] Pain [ ] Swelling [ ] Stiffness [ ] Burning [ ] Tingling [ ] Numbness

[ ] Weakness [ ] Instability [ ] Skin or nail change [ ] Wound [ ] Other _____

Pain over the past week 0 = no pain | 10 = worst pain imaginable

Current ____ /10 Average ____ /10 Worst ____ /10 [ ] No pain

Pattern [ ] First steps [ ] Standing [ ] Walking [ ] At rest [ ] At night [ ] Other _____

What makes symptoms worse? What helps?

_____

_____

Earlier Evaluation and Treatment

Include shoes, orthotics, braces, therapy, exercises, medication, injections, surgery, and other care. Attach reports if available.

Treatment or test and date	Result or benefit	How long it helped

Have you ever felt “I have never been the same since…”? Please explain if relevant.

_____

_____

What explanation or diagnosis have you been given? What remains unanswered?

_____

PATIENT INTAKE

Your Health History

Patient name _____ Date of birth _____

Check conditions you have now or have had in the past. Add details below, including dates and whether a condition is active, resolved, or uncertain.

Medical Conditions

[ ] Diabetes [ ] Prediabetes [ ] Thyroid disorder [ ] Osteoporosis [ ] Kidney disease

[ ] High blood pressure [ ] Heart disease [ ] Stroke or TIA [ ] Poor circulation

[ ] Blood clot [ ] Bleeding disorder [ ] Leg swelling [ ] Lung disease or asthma

[ ] Sleep apnea [ ] Liver disease [ ] Digestive condition [ ] Cancer

[ ] Arthritis [ ] Gout [ ] Autoimmune condition [ ] Frequent or serious infections

[ ] Neuropathy [ ] Neurologic condition [ ] Seizures [ ] Fainting or dizziness

[ ] Depression [ ] Anxiety [ ] Chronic pain [ ] Skin condition [ ] Slow wound healing

[ ] Other _____ [ ] None known [ ] Prefer to discuss

Please explain checked conditions, important dates, and current treatment.

_____

_____

_____

If known A1c _____ Date _____ Height _____ Weight _____ Recent change _____

Pregnant, possibly pregnant, or breastfeeding [ ] Yes [ ] No [ ] Not applicable

Symptoms to Discuss

Mark symptoms that are new, ongoing, or unexplained. This form is reviewed during your visit; it is not monitored for urgent concerns.

[ ] Fever [ ] Unexplained weight change [ ] Fatigue [ ] Chest discomfort

[ ] Shortness of breath [ ] Calf pain with walking [ ] Foot pain at rest

[ ] Cold or discolored feet [ ] Open wound [ ] New weakness or loss of sensation

[ ] Back or neck pain [ ] Joint pain or stiffness [ ] Headaches [ ] Vision changes

[ ] Bladder or bowel changes [ ] Balance changes [ ] Other _____

Describe symptoms, when they started, and whether another clinician evaluated them.

_____

_____

Family Health History

List relevant conditions in close relatives, such as diabetes, neuropathy, circulation problems, arthritis, clotting disorders, or inherited conditions. Include the relationship.

_____

_____

PATIENT INTAKE

Medications Allergies and Procedures

Patient name _____ Date of birth _____

Medications and Supplements

List prescriptions, nonprescription medicines, supplements, herbs, cannabis, creams, and drops. You may attach a list or photo.

[ ] List attached [ ] No medicines or supplements

Name and strength	Dose and frequency	Reason or prescriber

Blood thinner or daily aspirin _____ Steroid or immune medicine _____

Recent medication changes or side effects _____

Preferred pharmacy _____ Phone _____

Allergies and Reactions

[ ] No known allergies [ ] Not sure

Include medicines, latex, adhesives, skin preparations, and other relevant substances. Describe the reaction rather than only naming the substance.

Substance	Reaction and approximate date

Surgeries Hospitalizations and Major Injuries

Include side or body area, date, complications, and recovery concerns.

Procedure injury or admission	Date and side	Recovery or complications

Any problems with anesthesia, postoperative infection, healing, or persistent pain?

_____

Upcoming surgery or procedure _____ Date _____

Surgeon _____ Current restrictions _____

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PATIENT INTAKE

Movement Function and Foot History

Patient name _____ Date of birth _____

Everyday Movement

Comfortable walking time _____ min Standing time _____ min Sitting time _____ min

Difficulty with [ ] Stairs [ ] Uneven ground [ ] Squatting [ ] Getting up from a chair

[ ] Dressing [ ] Driving [ ] Work [ ] Exercise [ ] Household tasks [ ] Other _____

Mobility aid [ ] None [ ] Cane [ ] Walker [ ] Wheelchair [ ] Other _____

Describe a usual day of movement, exercise, work, or caregiving. What has changed?

_____

_____

Balance and Sensation

Falls in the past 12 months _____ Near falls _____ Injuries from a fall _____

[ ] Fear of falling [ ] Dizziness [ ] Trouble sensing the ground [ ] Foot catching or dragging

When do you feel unsteady? Do you notice weakness, altered sensation, or coordination?

_____

_____

Foot Ankle and Related History

[ ] Sprains [ ] Fractures [ ] Tendon injury [ ] Plantar fasciitis or heel pain

[ ] Bunions or toe deformity [ ] Flat or high arches [ ] Toe walking or intoeing

[ ] Nail problems [ ] Calluses [ ] Wounds or ulcers [ ] Foot or ankle surgery

[ ] Hip or knee symptoms [ ] Back symptoms [ ] Joint replacement [ ] Other _____

Add dates, side, repeated injuries, and previous treatments or restrictions.

_____

_____

Shoes and Supports

Usual shoe types _____ Size _____ Width _____ Hours worn _____

Supports [ ] None [ ] Store bought insert [ ] Custom orthotic [ ] Brace [ ] Other _____

Which shoes or supports help? Which worsen symptoms? Any recent footwear changes?

_____

_____

Are there movements or activities you avoid? What concerns you about doing them?

_____

_____

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PATIENT INTAKE

Daily Life Recovery and Care Preferences

Patient name _____ Date of birth _____

Sleep Energy and Recovery

Sleep per night _____ hours Sleep quality [ ] Restful [ ] Variable [ ] Poor

[ ] Symptoms interrupt sleep [ ] Snoring [ ] Daytime sleepiness [ ] Shift work

Energy 0 = no energy | 10 = your usual best energy Current energy ____ /10

What restores you? What makes rest or recovery difficult?

_____

_____

Nutrition and Habits

Describe your usual eating pattern, hydration, and any dietary needs or restrictions.

_____

_____

Nicotine or tobacco [ ] Never [ ] Former [ ] Current Type and amount _____

Alcohol _____ drinks per week Cannabis or other substances _____

Anything affecting appetite, nutrition, or access to food _____

Stress Support and Practical Needs

Stress 0 = none | 10 = overwhelming Current stress ____ /10

What responsibilities, life changes, or practical barriers affect your care or recovery?

_____

_____

Who can help if needed _____

Possible barriers [ ] Time [ ] Cost [ ] Transportation [ ] Caregiving [ ] Work demands

[ ] Difficulty following a plan [ ] Limited support [ ] Other _____

Care Preferences

What has helped you feel heard and safe in healthcare? What would you like done differently?

_____

_____

Care priorities to discuss [ ] Understanding my symptoms [ ] Movement and footwear

[ ] Recovery habits [ ] Home care [ ] Understanding treatment options

[ ] Prefer to discuss in person [ ] Other _____

Any beliefs, cultural needs, touch preferences, or experiences you want us to consider?

_____

These optional answers express preferences and do not provide consent for a treatment. You may leave sensitive questions blank and discuss them privately.

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PATIENT INTAKE

Your Goals and Meaningful Activities

Patient name _____ Date of birth _____

What would a successful outcome look like to you?

_____

_____

Why does this matter now? What would you most like to return to or begin?

_____

_____

Three Activities You Want to Regain

Patient Specific Functional Scale activity record

Choose three important activities limited by your current problem. Be specific, such as walking the dog for 20 minutes or standing long enough to prepare dinner. Rate your current ability for each.

0 = cannot do the activity | 10 = can do it at your level before this problem

Activity and usual duration or demand	Current ability 0 to 10	Why it matters

If the problem has always been present or you cannot identify a prior level, leave the score blank and discuss an appropriate measure with your physician.

Activity you most want to prioritize _____

Desired timeframe or important upcoming event _____

Readiness and Shared Planning

Confidence in following a plan 0 = none | 10 = very confident ____ /10

What would increase your confidence? What concerns or limitations should we plan around?

_____

_____

What is one realistic step you would feel ready to take?

_____

What have we not asked that you would like us to understand?

_____

Completed by [ ] Patient [ ] Patient with assistance [ ] Representative

If assisted Name _____ Relationship _____

Patient or representative signature _____ Date _____

I completed this history to the best of my knowledge. This confirms history only; agreements are separate.