

# Foot & Ankle Care of Boulder

Thomas E. Shonka, DPM \*ϕ

1400 28<sup>th</sup> Street, Suite 2  
Boulder, CO 80303  
Office: (303) 449-2000  
Fax: (303) 449-9475  
[www.facboulder.net](http://www.facboulder.net)

John S. Jachimiak, DPM \*°

**PLEASE PRINT LEGIBLY IN INK**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First (Legal): \_\_\_\_\_ Middle Initial \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_ Cell/Pager #: ( ) \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M F Marital Status: M S W O

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ ext \_\_\_\_\_

Spouse: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

May we contact you at your home #? Y N If no, please indicate which # you would like us to contact you ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**Primary Insurance Information:**

Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_  
(if different than above) (City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell/Pager #: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Secondary Insurance Information:**

Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_  
(if different than above) (City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell/Pager #: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Person Responsible for Bill:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(if different than above) (City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell/Pager #: ( ) \_\_\_\_\_

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I hereby acknowledge and agree that if my account becomes delinquent it will be subject to collection service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon on all such amounts outstanding. I certify that the information provided is correct to the best of my knowledge. I authorize the release of any pertinent information regarding my medical care, and assignment of benefits from my insurance company to my Physician.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

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## EXERCISE SURVEY

1. NAME: \_\_\_\_\_

2. AGE: \_\_\_\_\_

3. ACTIVITIES/EXERCISES DONE REGULARLY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. FREQUENCY OF ABOVE ACTIVITIES: \_\_\_\_\_

\_\_\_\_\_

5. DO YOU USE PADS, ARCH SUPPORTS, OR ORTHOTICS NOW?

YES          NO          WHICH? : \_\_\_\_\_

6. WHAT IS THE LONGEST PERIOD OF REST FROM EXERCISE YOU HAVE HAD IN THE LAST YEAR? : \_\_\_\_\_

7. WHAT ARE YOUR SHORT TERM AND LONG TERM GOALS?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## MEDICAL HISTORY

(Confidential Information-Important for Our Files and Your Health)

Family Physician: \_\_\_\_\_

Has He/She referred you to our office? \_\_\_\_\_

Have you seen another Podiatrist? YES NO Name: \_\_\_\_\_

Why did you see your former Podiatrist? \_\_\_\_\_

\_\_\_\_\_

What is the reason for your visit to our office? \_\_\_\_\_

\_\_\_\_\_

What treatments have been done up to this point (including orthotics/arch supports)?

\_\_\_\_\_

\_\_\_\_\_

Please list all medicines that you use: \_\_\_\_\_

\_\_\_\_\_

Please list all medicines that you are ALLERGIC to: \_\_\_\_\_

\_\_\_\_\_

FOR WOMEN ONLY: Are you pregnant? YES NO If yes, how many months \_\_\_\_\_

Indicate which of your immediate relatives have had any of the following diseases:

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_

Heart Trouble \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Kidney Disease \_\_\_\_\_ Mental/Emotional Illness \_\_\_\_\_

Stroke \_\_\_\_\_ Arthritis \_\_\_\_\_

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Podiatric Medicine & Surgery – Sports Medicine  
\*Diplomat, American Board of Podiatric Surgery  
\*Fellow, American College of Foot & Ankle Surgeons  
ϕ Fellow, American Academy of Podiatric Sports Medicine  
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Please check "Yes" or "No" to indicate if you have had any of the following problems:

| YES | NO | NATURE OF PROBLEM                                      | COMMENTS AND GIVE APPROXIMATE DATE |
|-----|----|--|------------------------------------|
|     |    | Recent Weight Loss                                     |                                    |
|     |    | Headaches  |                                    |
|     |    | Trouble with Hearing/Vision                            |                                    |
|     |    | Allergies/Hay Fever                                    |                                    |
|     |    | Asthma   |                                    |
|     |    | Thyroid  |                                    |
|     |    | Diabetes   |                                    |
|     |    | Skin   |                                    |
|     |    | Anemia   |                                    |
|     |    | Heart  |                                    |
|     |    | Mitral Valve Prolapse/Heart Murmur                     |                                    |
|     |    | Chest Pain   |                                    |
|     |    | High Blood Pressure                                    |                                    |
|     |    | Circulation  |                                    |
|     |    | Swelling in Feet or Ankles                             |                                    |
|     |    | Lungs (Pneumonia, TB, etc.)                            |                                    |
|     |    | Shortness of Breath(Cough, Pleurisy, Wheezing)         |                                    |
|     |    | Liver Disease, Gall Bladder Disease or Jaundice        |                                    |
|     |    | Stomach Trouble  |                                    |
|     |    | Arthritis  |                                    |
|     |    | Gout   |                                    |
|     |    | Kidney Disease or Stones                               |                                    |
|     |    | Cancer   |                                    |
|     |    | Bleeding Tendency                                      |                                    |
|     |    | Scarring Tendency                                      |                                    |
|     |    | Joint Pain or Stiffness                                |                                    |
|     |    | Numbness in Feet or Legs                               |                                    |
|     |    | Cramps in Feet or Legs                                 |                                    |
|     |    | Low Back Pain  |                                    |
|     |    | Do You Smoke? How much?                                |                                    |
|     |    | Do You Take Any Drugs? (Illegal or Legal?)<br>How Much |                                    |
|     |    | Psychiatric  |                                    |

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| YES | NO | NATURE OF PROBLEM               | COMMENTS/APPROXIMATE DATE |
|-----|----|---------------------------------|---------------------------|
|     |    | Fainting or Convulsions         |                           |
|     |    | Strokes                         |                           |
|     |    | Pain in Other Areas             |                           |
|     |    | Other Illnesses or Problems     |                           |
|     |    | HIV Positive                    |                           |
|     |    | Do you drink alcohol? How much? |                           |

Please give detail of any:

| OPERATIONS/SERIOUS INJURIES | APPROX. DATE | PHYSICIAN | HOSPITAL |
|-----------------------------|--------------|-----------|----------|
|                             |              |           |          |
|                             |              |           |          |
|                             |              |           |          |

7. Have you had physical therapy? When? Where? For what condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Is there anything you wish to tell the doctor privately? Yes \_\_\_\_\_ No \_\_\_\_\_

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

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