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Patient Intake Form

Name: _____		Birthdate: _____	
		Male	Female (circle one)
Address	City	State	Zip Code
Home: _____	Cell: _____	Work: _____	
Email _____			
Emergency Contact		Relation:	
Phone: _____			
How did you hear about us?			

Who is your Primary Care Physician?			
Name: _____			

Address	City	State	Zip Code
Phone: _____			

Name of Insurance Carrier _____	
Name of Policy Holder _____	Relation to Policy Holder _____
Program Name _____	
ID No. _____	Group/Policy No. _____

Occupation _____	
Employer/School _____	_____
Phone: _____	

What is the reason for your visit? _____

When did this begin? _____

What is the current status of the concern? _____

What is it like? (please be descriptive) _____

How bad is it? (pain on scale 1-10, 10 worst possible) _____

Does anything make it better or worse? _____

Has anything else accompanied this concern? _____

Has any treatment begun? If so, what? _____

Medical History

Please list all medications you are currently taking.

Please list all herbs/vitamins you are currently taking.

Please list all known allergies. _____ None known (circle if applicable)

Please list all major surgeries and hospitalizations.

What do you do in your spare time? Hobbies? _____

How much sleep do you get? Quality? _____

How much exercise do you get? min/day? What activities? _____

Family Medical History

Please list all major illnesses in your family and relation. (i.e. cancer, heart disease, diabetes . . .)

Have you ever experienced, been diagnosed with or received treatment for the following?
 (please circle all that apply)

General	Breasts	Urinary	HEENT
Weakness	Lumps	Frequent urination	Headache
Fatigue	Pain or discomfort	Urination at night	Dizziness
Fever	Nipple discharge	Urgency	Fainting
Skin	Self Breast Exams	Pain or discomfort	Glasses or contacts
Rashes	Respiratory	Blood in urine	Eye pain
Lumps	Coughing blood	Kidney stones	Blurry vision
Itching	Shortness of breath	Incontinence	Cataracts
Changes in hair or nails	Difficulty breathing	Dribbling	Glaucoma
Gastrointestinal	Wheezing	Decreased force	ringing in the ears
Difficulty swallowing	Asthma	Peripheral Vascular	Vertigo
Heartburn	Emphysema	Leg cramps	Ear discharge
Change in appetite	Pneumonia	Varicose veins	Loss of hearing
Nausea	Tuberculosis	Blood clots	Frequent sinus troubles
Blood in stools	Cardiovascular	Musculoskeletal	Hay fever
Hemorrhoids	High blood pressure	Muscle or joint pain	Bleeding gums
Constipation	Rheumatic Fever	Stiffness	Dry mouth
Diarrhea	Heart murmurs	Gout	Frequent sore throats
Abdominal pain	Chest pain	Neurologic	Hoarseness
Jaundice	Palpitations	Fainting	Endocrine
Hepatitis	Shortness of breath	Seizures	Heat or cold intolerances
Hematologic	Edema	Weakness	Excessive sweating
Anemia	Neck	Paralysis	Excessive thirst
Easy bruising	Lumps	Numbness or loss of sensation	Nervousness
Transfusions	Goiter	Tingling	Mood changes
		Tremors	Memory change