**Patient Intake Form**

**Name:** **Date of Birth:** **Today’s Date:**

**I Wish to be Contacted in the Following Manner**

Email Address: Phone Number Cell/Home/Work:

Mailing Address:

*Street City State Zip*

I consent to receiving **appointment reminders**, **my healthcare information**, **confidential documents**, through above contact methods.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information

**unless I request a change in writing**.

**Emergency Contact Name: Phone: Relation:**

**Health Insurance Policy (Primary / Secondary / Self-pay) Date Effective Policy Number Group Number**

**What’s Bothering You?** (what are you here for?)

Aching  Burning  Comes and Goes  Constant  Cramping  Dizzy  Dull

Electric Shock  Numbness  Piercing  Pressure  Pulsating  Radiating  Sharp

☐ Shooting  Soreness  Squeezing  Stabbing  Tender  Throbbing  Tingling

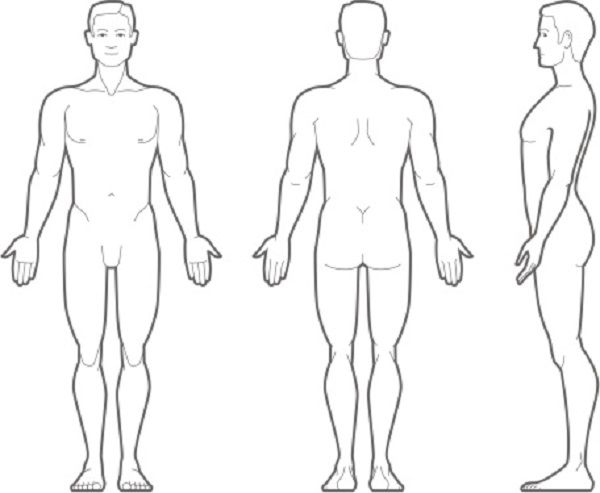
**When did it start?**

**How often are the symptoms?**

**How severe are the symptoms?**

**How have you managed the symptoms?**

**Botox Treatments? Y / N**

**Allergies:** (drugs, food, and severity of reaction.)



Circle or Cross the areas of discomfort

**Past Surgeries and Procedures**

**Procedure Admission Date Length of Stay**

**Preventative Care** List ongoing Medical Treatments, Special Diets, and Physical Therapies

**Social history**

**Tobacco**

\_\_ Current Packs per Day \_\_ Never smoked ­­\_\_ Tried to quit before Date Quit

**Alcohol**

\_\_ #Drinks per day \_\_ Social Drinker \_\_ Non-Drinker

**Caffeinated Drinks**

\_\_ #Coffee/Tea Daily \_\_ #Pop/Soda Daily \_\_ Cold Drinks Preferred \_\_ Hot/Warm Drinks Preferred

**Do you currently use Marijuana/Cannabis (YES / NO)**

**If YES, how often and by what method? Does it help alleviate symptoms of your qualifying condition?**

**Family History (Chronic conditions)**

Father Mother Siblings

Grandfather F/M Grandmother F/M

**OB and Pregnancy History**

\_\_ Age Onset of menses \_\_ Irregular Menses \_\_ Contraceptives \_\_ HRT Use

\_\_ Age of Menopause \_\_ Fertility Drugs \_\_ Abnormal Pap Smears

\_\_ # Pregnancies \_\_ # Full Term \_\_ # Pre Term \_\_ # Miscarriage

**Medications** (List medications taken past three months)

**Name and Dosage How often Taken Reason for Taking Prescribing Physician**

**Non-Prescription Drugs Taken** (Vitamins, Herbs, Etc.)

**Review of Systems** Blood Type and Rh:

**General Sex:** \_\_ Male \_\_ Female \_\_ Undifferentiated

\_\_ Fever \_\_ Weight Loss/Gain \_\_ Fatigued \_\_ Hyperactive

\_\_ Chills \_\_ Poor Appetite \_\_ Depressed \_\_ Exposure to Foreign Countries

\_\_ Night Sweats \_\_ Sleep Issues Other:

**Skin**

\_\_ Rashes \_\_ Open Sores \_\_ Blisters \_\_ Herpes

\_\_ Psoriasis Other:

**HEENT**

\_\_ Cataracts \_\_ Poor Hearing \_\_ Sinus Infection \_\_ Headaches

\_\_ Glaucoma \_\_ Ringing in Ears \_\_ Dry Mouth \_\_ Double Vision

\_\_ Bloody Nose \_\_ Sore Throat \_\_ Blurred Vision \_\_ Dentures

\_\_ Nasal Allergies Other:

**Respiratory**

\_\_ COPD/Emphysema \_\_ Pulmonary Fibrosis \_\_ Chronic Bronchitis \_\_ Shortness of Breath

Other:

**Cardiovascular**

\_\_ Poor Circulation \_\_ Irregular Heartbeat \_\_ High Blood Pressure \_\_ Chest Pains

Other:

**Gastrointestinal**

\_\_ Stomach Pains \_\_ Diverticulitis \_\_ Hepatitis \_\_ Gastritis

\_\_ Liver Cirrhosis \_\_ Ulcerative Colitis \_\_ Gall Stones \_\_ Polyps

\_\_ Crohn’s Disease \_\_ Diarrhea \_\_ Heartburn Other:

**Genitourinary**

\_\_ Kidney Stones \_\_ Bladder Infection \_\_ Prostate Problems \_\_ UTI (burning)

\_\_ Urinary Incontinence \_\_ STDs Other:

**Musculoskeletal** *(the common complaints)*

\_\_ Osteoarthritis \_\_ Stiff Joints \_\_ Scoliosis \_\_ Hand Problems \_\_ Rheumatoid Arthritis

\_\_ Broken Bones \_\_ Herniated Disc \_\_ Hip Problems \_\_ Lupus \_\_ Neck Problems

\_\_ Shoulder Problems \_\_ Knee Problems \_\_ Spine Arthritis (A.S.) \_\_ Back Problems \_\_ Elbow Problems

\_\_ Ankle Problems \_\_ Swollen Joints \_\_ Wrist Problems \_\_ Foot Problems

Describe:

**Endocrine**

\_\_ Insulin Dependent Diabetes \_\_ *Hypo*thyroidism \_\_ Cushing Syndrome \_\_ Addison’s Disease

\_\_ Non-Insulin Dependent Diabetes \_\_ **Hyper**thyroidism \_\_ Goiter Other:

**Lifestyle/Exercise**

I’m happy with my **work** relationships Satisfied Dissatisfied Indifferent Explain

I’m happy with my **intimate** relationships Satisfied Dissatisfied Indifferent Explain

I’m happy with my **family** relationships Satisfied Dissatisfied Indifferent Explain

Describe Weekly Exercise (be honest)

Describe Daily Food Intake (won’t judge)

Describe Sleeping Habits (promise)

Describe Work Posture/Hazards

I, have filled this to the best of my knowledge.

(Patient Name)

(Patient Signature) (Today’s Date)