Patient Intake Information

Date:_____

_____

(Legal) First Name (Legal) MI (Legal) Last Name DOB: Age

Street _____ Apt. _____

City _____ State _____ Zip _____

Social Security #: _____ Marital Status: / / S / / M / / W / / D Spouse: _____

Language: _____English _____Spanish _____Indian _____Japanese _____Chinese _____Korean _____French _____German

_____Russian Other _____

Race/Ethnicity: _____White _____American Indian or Alaska Native _____Asian _____Native Hawaiian/Other Pacific Islander

_____Black or African American _____Hispanic or Latino _____Decline to Answer

Contact Info: Home Ph: _____ Work Ph: _____ Cell Ph: _____

Cell Carrier: _____ Email Hm: _____

Email Wk: _____

Contact Preference: ___Home Ph ___Work Ph ___Cell Ph ___Email Hm ___Email Wk ___Postal Mail

Emergency Contact: _____ Phone: _____

Who referred you to our office? _____ Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____

City Street State Zip

Insurance Information: *A copy of your insurance card[s] will be made, in addition, please complete the information requested below:*

Are you the policy holder? / / Y / / N If No, who is? ___Spouse ___Parent ___Employer Other _____

_____

Policy Holder's First Name MI Last Name DOB:

Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

Do you have secondary insurance? / / Y / / N If yes, please complete the following:

_____

Policy Holder's First Name MI Last Name DOB:

Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

Date: _____

First Name MI Last Name

Patient History

Please give a brief description of the problem[s] you are experiencing:

_____

_____

_____

Is/Are the problem[s] getting better? / / Y / / N or getting worse? / / Y / / N When did the problem[s] start? _____

_____

What appears to be the initial cause? _____

_____

Are you seeing any other providers for other problems or health conditions? / / Y / / N

Please list the problem[s], date problem[s] began and Provider[s] treating you for the condition[s]:

_____

_____

_____

Past History

Have you --- If yes, please list the date and the name of the treating provider.

ever been diagnosed with hypertension? / / Y / / N _____

been hospitalized in the last 5 years? / / Y / / N _____

been diagnosed with Diabetes? / / Y / / N _____

Type I ___ Type II___

Do you smoke? ___Never ___Former Smoker ___Current/Every Day Smoker ___Current Some Day[s] Smoker

Vitals (for office use only) Height _____ Weight _____ Blood Pressure _____

Medications

What medications are you currently taking? Please includle all non-prescription and over the counter vitamins, herbs, minerals, etc.:
List Date Started, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:
Please be as specific as possible.

_____

_____

_____

_____

_____

Do you have allergies? / /Food / /Environmental / /Medication

List Type of Allergy and Reaction[s]

_____

_____

_____

_____

Thank you for your cooperation!