Patient Intake Information

Date: _____

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

Street _____ Apt. # _____
City _____ State _____ Zip _____
Marital Status [ ] S [ ] M [ ] W [ ] D
Social Security # _____ Spouse _____

Language: English ____ Spanish ____ Other _____
Race/Ethnicity: White ____ American Indian/Alaskan Native ____ Asian ____ Native Hawaiian/Other Pacific Islander ____ African American ____ Hispanic ____ Decline to Answer ____

Contact Info: Home # _____ Cell # _____
Work # _____
Cell Carrier: _____ Email (Home) _____
Email (Work) _____
Contact Preference: Home # ___ Cell # ___ Work # ___ Email (Home) ___ Email (Work) ___ Posted Mail ___

Emergency Contact: Name _____ Relationship _____
Phone # _____

Insurance Information: *A copy of your insurance card(s) will be made. In addition, please complete the information requested below:*
Do you have Health Insurance? Yes/No
Name of Health Insurance _____
Member ID # _____
Group # _____
Do you have Secondary Health Insurance? Yes/No
Name of Secondary Health Insurance _____
Member ID # _____
Group # _____
Were you in an auto or personal injury accident? Yes/No
Is this work related? Yes/No
Name of Insurance Company _____
Claim # _____
Policy # _____
Date of Injury _____

Patient History

Who referred you to this office? _____

Please give a brief description of the problem(s) you are experiencing:

_____

_____

_____

Are the problem(s) getting better? [ ] Y [ ] N Worse? [ ] Y [ ] N When did the problem(s) start? _____

_____

What appears to be the initial cause? _____

_____

Are you seeing any other providers for this or any other health conditions? [ ] Y [ ] N
Please list the problems(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 name of 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 ___ Current ___ How many packs/day ___

Alcohol: Never ___ Casual drinker ___ Moderate drinker ___ Heavy drinker ___

Caffeine: None ___ <3 cups/day ___ >3 cups/day ___ >6 cups/day ___

Drug Use: None ___ Recreational ___ Addiction ___

Exercise: Never ___ Daily ___ Weekly ___ What kind? _____ How long? _____

Have you had an X-ray, CT scan, or MRI anywhere in the last year? [ ] Y [ ] N Body Part: _____

Family History

Relationship	*History*	*Deceased y/n*	*Illness*
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings (list below)			

Occupational History (most recent):

Start Date (approx):_____ End Date (approx): _____ Occupation: _____

Status: In School: _____ Employed: _____ Unemployed: _____ Retired: _____

Medications:

None: _____

Name	*Date Started*	*Generic*	*Dosage*	*Frequency*	*Duration*

Allergies:

None: _____

Allergy	*Date Started*	*Type (food, environment, or medical)*	*Reaction*

Surgeries:

None: _____

Surgery	*Date*	*Results*

Hospitalizations:

None: _____

Reason	*Date*	*Hospital*

Major Illness:

None: _____

Illness	*Date (approx)*	*List Conditions*

Reported Tests:

None: _____

Type	*Date*	*Results*
Cholesterol		
Colonoscopy		
Biopsy		
Mammogram		
Pap Smear		
Bone Density Test		
Blood Glucose		
Lipid Panel		

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Marital Status [ ] S [ ] M [ ] W [ ] D
Social Security # _____ Spouse _____

Language: English ____ Spanish ____ Other _____
Race/Ethnicity: White ____ American Indian/Alaskan Native ____ Asian ____ Native Hawaiian/Other Pacific Islander ____ African American ____ Hispanic ____ Decline to Answer ____

Contact Info: Home # _____ Cell # _____
Work # _____
Cell Carrier: _____ Email (Home) _____
Email (Work) _____
Contact Preference: Home # ___ Cell # ___ Work # ___ Email (Home) ___ Email (Work) ___ Posted Mail ___

Emergency Contact: Name _____ Relationship _____
Phone # _____

Insurance Information: *A copy of your insurance card(s) will be made. In addition, please complete the information requested below:*
Do you have Health Insurance? Yes/No
Name of Health Insurance _____
Member ID # _____
Group # _____
Do you have Secondary Health Insurance? Yes/No
Name of Secondary Health Insurance _____
Member ID # _____
Group # _____
Were you in an auto or personal injury accident? Yes/No
Is this work related? Yes/No
Name of Insurance Company _____
Claim # _____
Policy # _____
Date of Injury _____

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Been hospitalized in the last 5 years?	[ ] Y [ ] N	_____
Been diagnosed with Diabetes?	[ ] Y [ ] N	_____

Type I ___ Type II ___

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Alcohol: Never ___ Casual drinker ___ Moderate drinker ___ Heavy drinker ___

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Exercise: Never ___ Daily ___ Weekly ___ What kind? _____ How long? _____

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Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings (list below)			

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Start Date (approx):_____ End Date (approx): _____ Occupation: _____

Status: In School: _____ Employed: _____ Unemployed: _____ Retired: _____

Medications:

None: _____

Name	*Date Started*	*Generic*	*Dosage*	*Frequency*	*Duration*

Allergies:

None: _____

Allergy	*Date Started*	*Type (food, environment, or medical)*	*Reaction*

Surgeries:

None: _____

Surgery	*Date*	*Results*

Hospitalizations:

None: _____

Reason	*Date*	*Hospital*

Major Illness:

None: _____

Illness	*Date (approx)*	*List Conditions*

Reported Tests:

None: _____

Type	*Date*	*Results*
Cholesterol		
Colonoscopy		
Biopsy		
Mammogram		
Pap Smear		
Bone Density Test		
Blood Glucose		
Lipid Panel		