

## 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 include 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!*