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**PATIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a patient of [HEALTHCARE FACILITY'S NAME]. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

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| **PATIENT DETAILS** |

**First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**:  Male  Female  Other

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP Code**: \_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile** **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity/Race**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_ **Height**: \_\_\_\_\_\_\_\_

**Primary Language**:  English  Spanish  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**:  Single  Married  Divorced  Separated  Widowed

**Spouse Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Spouse Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **EMERGENCY CONTACT** |

**Emergency Contact Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile** **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PRIMARY INSURANCE POLICY** |

**Primary Insurance Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Type**:  HMO  PPO  Medicare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete the following if you are ***not*** the policyholder for your primary insurance:

**Insurance Policyholder**:  Spouse  Child  Parent  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECONDARY INSURANCE POLICY (IF ANY)** |

**Secondary Insurance Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Type**:  HMO  PPO  Medicare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete the following if you are ***not*** the policyholder for your secondary insurance:

**Insurance Policyholder**:  Spouse  Child  Parent  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TREATING PHYSICIANS** |

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all other active treating physicians:

**Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Specialty**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Specialty**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Specialty**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Specialty**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ALLERGIES** |

List your allergies and describe the reactions to your body:

**Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reaction**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reaction**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reaction**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reaction**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MEDICATION** |

List the medications you are currently taking including the dosage:

**Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dose**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dose**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dose**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dose**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY HEALTH HISTORY** |

List any major conditions/illnesses that your immediate family members have had:

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative** | **Condition** | **Living?** | **If deceased, at what age?** |
| Mother |  | Y  N |  |
| Father |  | Y  N |  |
| Sibling |  | Y  N |  |
| Other: |  | Y  N |  |
| Other: |  | Y  N |  |

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| **SURGICAL HISTORY** |

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Doctor** | **Location** | **Year** |
|  |  |  |  |
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| **MEDICAL HISTORY** | | | |

Have you ever had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Anemia | Y  N | Hypertension | Y  N |
| Arthritis Conditions | Y  N | Male Hypogonadism | Y  N |
| Asthma | Y  N | Hypothyroidism | Y  N |
| Atrial Fibrillation | Y  N | Infection Problems | Y  N |
| Bleeding Problems | Y  N | Insomnia | Y  N |
| Benign Prostatic Hyperplasia | Y  N | Irritable Bowel Syndrome | Y  N |
| Coronary Artery Disease | Y  N | Kidney Problems | Y  N |
| Cancer | Y  N | Menopause | Y  N |
| Cardiac Arrest | Y  N | Migraines/Headaches | Y  N |
| Celiac Disease | Y  N | Neuropathy | Y  N |
| Chest Pain | Y  N | Onychomycosis | Y  N |
| Congestive Heart Failure | Y  N | Organ Injury | Y  N |
| Chronic Fatigue Syndrome | Y  N | Osteoporosis | Y  N |
| Depression | Y  N | Pulmonary Embolism | Y  N |
| Diabetes | Y  N | Seizure Disorders | Y  N |
| Drug/Alcohol Abuse | Y  N | Shortness of Breath | Y  N |
| Erectile Dysfunction | Y  N | Sinus Conditions | Y  N |
| Fibromyalgia | Y  N | Stroke | Y  N |
| Gerd | Y  N | Syndrome X | Y  N |
| Heart Disease | Y  N | Tremors | Y  N |
| Hyperinsulinemia | Y  N | Wheat Allergy | Y  N |
| Hyperlipidemia | Y  N |  |  |

List any other medical problems that you have had:

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| **HEALTH CONCERNS** |

**What’s your primary health concern?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximately when did this issue begin?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the issue cause you pain?**  Yes  No

* If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How has the pain changed since it began?**  Increased  Decreased  Unchanged

**How quickly did you current pain begin?**  Gradually  Suddenly

**How often does your pain occur?**  Constantly  Occasionally  Rarely

**When is your pain at its worst?**  Morning  Afternoon  Evening  Night

**What are your current symptoms?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the following that describe your pain:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Aching |  | Numbness |  | Spasming |  | Throbbing |  |
| Cramping |  | Shock-like |  | Squeezing |  | Tingling |  |
| Dull |  | Shooting |  | Stabbing/Sharp |  | Tiring/Exhausting |  |
| Hot/Burning |  |  |  |  |  |  |  |

List any other health concerns that you would like us to know about:

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| **SOCIAL HISTORY** |

**Do you currently consume alcohol?**  Yes  No

* How many drinks per week? \_\_\_\_\_\_\_\_

**Do you currently smoke?**  Yes  No

* What do you smoke?  Tobacco  Marijuana  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How many cigarettes do you smoke per day? \_\_\_\_\_\_\_\_

**Do you currently use any other drugs?**  Yes  No

* What other drugs do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How often?  Daily  Weekly  Occasionally  Rarely

**Do you drink caffeine?**  Yes  No

* How many cups per day? \_\_\_\_\_\_\_\_

**Are you sexually active?**  Yes  No

**Would you like to be checked for STIs?**  Yes  No

**How frequently do you exercise?**  Daily  Weekly  Occasionally  Rarely

**Are you on a special diet?**  Yes  No

* What diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete the following if applicable:

**Are you planning a pregnancy?**  Yes  No

**Are you pregnant now?**  Yes  No

**What type of contraception do you currently use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last menstrual cycle?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PREFERRED PHARMACY** |

**Pharmacy Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP Code**: \_\_\_\_\_\_\_\_

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| **PATIENT CONSENT** |

By signing below, I hereby acknowledge, agree, and authorize all of the following:

1. **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
2. **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility’s Notice of Privacy Practices prior to signing this form.
3. **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility’s Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
4. **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
5. **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
6. **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

**Patient Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_