New Patient Intake Form

Please note all the information will remain confidential.

PATIENT INFORMATION

Name: ____ Date of Birth: ______________________

Sex: ______ Address: ____

City: _____________________________ State: ____________ Zip Code: ________________

Home Phone:___________________________ Mobile Phone: ____________________________

EMERGENCY CONTACT

Name: ____ Relationship: ______________________

Home Phone: ___________________________ Mobile Phone: ___________________________

INSURANCE INFORMATION

Insurance Carrier: ______________________ Insurance Plan: ____________________________

Policy Number: _________________________ Group Number: ___________________________

MAIN REASON FOR TODAY'S VISIT

GOALS FROM TODAY'S VISIT

MEDICAL HISTORY

List all your medical conditions (current and past) below:

SURGICAL HISTORY

List all past surgeries below:

FAMILY HISTORY

List history of medical conditions in parents, siblings and children below:

PERSONAL HISTORY:

Occupation: ____________________________ Allergies: __________________________________

Marital Status: _______________________ Children: ____________________________________

Living with: ____

Herbal Supplements: ____

Medication List (please attach medication list):

____

____

History of Smoking: Y/ N. How many cigarettes a day? ____ Duration ______________________

History of Alcohol Use: Y/ N. How many drinks a day? ____ Type ___________ Duration _______

History of Non-Prescription Drug Use: Y/ N. Names _________________ Duration ___________

COMMENTS:

____

____