Confidential Intake Form Date: / / 2020

Personal Information

Patient's Name: _____
Last MI First

DOB: _____SS#: _____

Birth Sex: □ Male □ Female Gender Identity: □ Male □ Female □ Other: _____

Marital Status: □ Single □ Married □ Divorced □ Other:

_____

Address:_____

City: _____ State: ____ Zip: _____

Phone: _____ □ Cell □ Home □ Work □ Other:

Email: (print clearly)

_____

How did you learn about our office?

_____

Emergency Contact

Emergency Contact Name: _____

Relationship: _____

Phone: (print clearly) _____

What is the primary reason for your visit today?

_____

When did your pain begin?

_____

How do you describe your pain?

_____

What is your Pain level now on a scale of 0-10_____ , 10 being let's go to ER

What makes it Better_____

Worse _____

Is there any Numbness - Tingling - Weakness?

_____

Initials: _____ Date: _____/_____/2020

Medical History - Do you have any history of the following conditions?

Hypothyroid	Y N	Liver Problems	Y N
Hyperthyroid	Y N	Stomach Problems	Y N
Asthma	Y N	Irritable Bowel Syndrome	Y N
C.O.P.D.	Y N	Irritable Bowel Disease	Y N
Sleep Apnea	Y N	Reflux (G.E.R.D.)	Y N
Coronary Artery Disease	Y N	Kidney Problems	Y N
Congestive Heart Failure	Y N	Osteoporosis	Y N
High Blood Pressure	Y N	Arthritis	Y N
Elevated Cholesterol	Y N	Blood Disorder	Y N
Heart Attack	Y N	Hepatitis	Y N
Implantable Devices	Y N	HIV or AIDS	Y N
Cardiac Arrhythmia	Y N	Glaucoma	Y N
Rheumatic Fever	Y N	Cancer	Y N
Diabetes	Y N		

Other Medical Conditions:

_____

_____

Prior Physician/Clinic Seen at:_____

Date: _____

Latest blood work (type and date):

_____

Hospitalizations and Surgeries -

Date	Reason and/or type of surgery
_____	_____
_____	_____
_____	_____

Current Medications - Include all prescriptions, over the counter medications, vitamins, supplements, and herbs.

Name of Medication	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Initials: _____ Date: _____/_____/2020

Allergies - Include allergies to medication, environmental, food, animal.

Allergen	Severity	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History -

Do you smoke tobacco?	Y	N	If yes, # & duration?	_____
Do you use marijuana?	Y	N	If yes how often?	_____
Do you drink alcohol?	Y	N	If yes, how much?	_____
Do you exercise regularly?	Y	N	If yes, how often?	_____
Are you sexually active?	Y	N	Male/Female/Both	_____
Do you use recreational drugs?	Y	N	Type?	_____

Review of Systems

Please Circle: C = a condition/symptom you **Currently** have; or

P = **Past** condition/symptom;

No Mark = Never had condition/symptom

General:

Weight: _____
Weight 1 yr ago: _____
Height: _____

Fever	C P
Fatigue	C P
Night Sweats	C P
Chills	C P
Weight loss	C P

Skin:

Rashes	C P
Eczema, Hives	C P
Acne	C P
Itching	C P
Dry skin	C P
Color changes	C P

Ears:

Hearing loss	C P
Ringing (tinnitus)	C P
Dizziness	C P
Ear pain	C P

Nose/Sinuses:

Frequent colds	C P
Congestion	C P
Sinus Infections	C P
Frequent Nosebleeds	C P

Mouth & Throat:

Frequent sore throat	C P
Difficulty swallowing	C P
Jaw/TMJ problems	C P
Canker sores (ulcers)	C P

Head:

Headaches	C P
Migraines	C P
Hair loss	C P

Eyes:

Changes in vision	C P
Double vision	C P
Eye pain	C P
Tearing or Dry eyes	C P
Eye discharge	C P
Light Sensitivity	C P

Cardiovascular:

Chest pain/angina	C P
Fluttering in chest	C P
Swelling in ankles	C P

Gastrointestinal:

Heartburn	C P
Nausea	C P
Vomiting	C P
Abdominal pain	C P
Diarrhea	C P
Constipation	C P
Blood in stool	C P
Hemorrhoids	C P

Urinary:

Painful urination	C P
Increased frequency	C P
Frequency at night	C P
Urgency	C P
Blood in urine	C P
Flank pain	C P
Incontinence	C P
Frequent urinary infections	C P

Male Reproductive:

Hernias	C P
Testicular lump	C P
Testicular pain	C P
Sexual difficulty	C P

Female Reproductive:

Date of last menses: _____

Length of cycle: _____

Irregular cycles	C P
Sexual difficulties	C P
Pain with intercourse	C P
Birth control?	C P

If yes what type:

_____

Neck:

Swollen Glands	C P
Goiter	C P
Pain or stiffness	C P

Respiratory:

Frequent cough	C P
Coughing up blood	C P
Shortness of breath	C P
Wheezing	C P
Pneumonia	C P

Musculoskeletal:

Joint Pain/stiffness	C P
Muscle spasm/cramps	C P
Muscle weakness	C P
Back pain	C P
Neck pain	C P

Endocrine/Heme:

Excessive thirst	C P
Cold/heat intolerance	C P
Excessive urination	C P
Excessive fatigue	C P
Easy bleeding bruising	C P
Varicose veins	C P

Neurological:

Tingling	C P
Tremor	C P
Seizures	C P
Numbness	C P
Paralysis	C P
Loss of memory	C P
Stroke	C P
Fainting	C P

Emotional:

Depression	C P
Anxiety	C P
Insomnia	C P
Excessive stress	C P
Mood swings	C P