Confidential Intake Form

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?

Location-

____

Onset-

____

Quality-

____

Pain level 0-10______

Makes it Better/Worse____

Any Numbness, Tingling, Weakness? _______

Where?

____

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

Condition	Y	N	Condition	Y	N
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

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

Allergen	Severity	Reaction
______________________	____________	______________________
______________________	____________	______________________
______________________	____________	______________________

Social History -

Do you smoke tobacco?	Y	N	If yes, how many per	____________________
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; 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

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

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

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

Tearing or Dry eyes C P
Eye discharge C P
Light Sensitivity C P

Wheezing C P
Pneumonia 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:
Duration of menses: ________________
Days you heavily bleed: ______________
Length of cycle: ________________
Irregular cycles C P
Sexual difficulties C P
Pain with intercourse C P
Menopausal symptoms C P
Birth control? C P
If yes what type:
____

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