<NAME OF CLINIC>

NEW PATIENT INTAKE FORM

Date:_____ Patient #_____ **Doctor/Provider:**_____

Name:_____ Primary Phone: _____ (circle) Home Cell Work

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Alternate Phone: _____

MAY WE: (circle all that apply) CALL CELL CALL HOME CALL WORK EMAIL MAIL **you about**

APPOINTMENT REMINDERS ACCOUNT UPDATES CLINIC EVENTS BIRTHDAYS/ANNIVERSARIES

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other/Non-Insured/Cash

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ PATIENT DOB _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

WHEN DID SYMPTOMS APPEAR? _____ Are they getting worse? □ YES □ NO

IF VISIT IS DUE TO ACCIDENT Date accident happened (if applicable): _____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? □Yes □ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? □ Yes □ No

If yes, describe:_____

Do you have any allergies of any kind? □ Yes □ No

If yes, describe:_____

Do you have any Congenital Condition? □Yes □ No If YES, Describe _____

_____

Women: Are you pregnant?_____ Date of last Menstrual Period _____

HEALTH ISSUES AND CONDITIONS: Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency _____		Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

HEALTH ISSUES AND CONDITIONS (Continued)

Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use - Daily Occasionally Never

_____ Drug Use - Daily Occasionally Never

_____ Tobacco Use - Daily Occasionally Never

_____ Caffeine - Daily Occasionally Never

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

REVIEWED BY:
DATE:
PRINT NAME: