Patient Intake Information

Date:___________________________

____
(Legal) First Name (Legal) MI (Legal) Last Name DOB: Age

Street ____ Apt.__________

City ____ State______________ Zip _________

Social Security #:___________________________Marital Status: [ ] S [ ] M [ ] W [ ] D Spouse: ______________

Language: ___English ___Spanish ___Indian ___Japanese ___Chinese ___Korean ___French ___German

___Russian ______________________________________Other

Race/Ethnicity:___White ___American Indian or Alaska Native ___Asian ___Native Hawaiian/Other Pacific Islander

___Black or African American ___Hispanic or Latino ___Prefer Not to Answer

Contact Info: Home Ph:___________________________ Work Ph:____________________ Cell Ph:____________________

Cell Carrier: ____ Email Hm: ____

Email Work: ____

Contact Preference: ___ Home Ph ___Work Ph ___Cell Ph ___Email Hm ___Email Wk ___Postal Mail

Emergency Contact:_______________________________________ Phone: ______________________________________

Who referred you to our office? ____

Your Occupation: ____Employer:______________________________

Employer Address: ____

City___________________________________ Street ________________________________State____ Zip_____________

Insurance Information: *A copy of your insurance card[s] will be made, in addition, please complete the information requested below:*

Are you the policy holder? [ ] Y [ ] N If No, who is? ___Spouse ___Parent ___Employer ________________Other

Policy Holder's First Name: ______________________MI___ Last Name: _______________________ DOB: __________

Policy Holder's Social Security #: ____

Policy Holder's Employer: ____

Date:_______________________________________

____

(Legal) First Name (Legal) MI (Legal) Last Name

Past History

Have you --

If yes, please list the date and name of the treating provider.

ever been diagnosed with Hypertension? [ ] Y [ ] N ____

been hospitalized in the last 5 years? [ ] Y [ ] N ____

been diagnosed with Diabetes? [ ] Y [ ] N ____

[ ] Type I [ ] Type II

Do you have a family history of cancer? If so, whom and type of cancer ____

Do you have a family history of heart disease? If so, whom? ____

Do you have a family history of high blood pressure? If so, whom? ____

Do you smoke? [ ] Never [ ] Former Smoker [ ] Current/Every Day Smoker [ ] Current/Some Day[s] Smoker

How often do you exercise? ____

How often do you have caffeine? ____________________________________

How often do you drink alcohol? ____________________________________

Have you ever had a stroke? _________

Have you ever lost consciousness? _________ If so, please explain: ____

Medications

What medications are you currently taking? Please include all non-prescription and over the counter vitamins, herbs, minerals, etc…

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Do you have allergies? [ ] Food [ ] Environmental [ ] Medication

If so, List Type of Allergy and Reaction[s]

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