Patient Intake Form

Patient Name _____ Date of Birth: _____

Referring Doctor: _____ Family Doctor: _____

Reason for visit: _____

Testing done for this reason: X-Rays Bone Scan CT Scan MRI EMG/NCV Lab Work (Circle all that apply)

Where was testing done: _____

Preferred Pharmacy: _____

If related to a work injury:

Company name: _____

Address: _____

Occupation/Job Title: _____

Have you reported the accident to your employer? ☐ Yes ☐ No

Were you referred by a Work Comp doctor? ☐ Yes ☐ No

Was this injury a result of a car accident? ☐ Yes ☐ No

Did the injury occur on another person's property? ☐ Yes ☐ No

Do you have an attorney representing you in a claim regarding the above injury? ☐ Yes ☐ No

Attorney Name & Address: _____

I certify, by my signature, that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I authorize this provider or their agents, to release any information including diagnosis and records of any treatment or examination rendered to me to third party payors and/or health practitioners. I hereby authorize third parties (insurance companies) to pay directly to this provider any insurance benefits due for services rendered on behalf of the patient. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

My signature below constitutes my acknowledgement that I have been offered a copy of the "Notice of Privacy Practices."

Signature: _____ Date: _____

Do you exercise for more than 30 minutes, 3-5 times weekly? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind? _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever had chemotherapy? ☐ Yes ☐ No

Have you ever had radiation? ☐ Yes ☐ No

Review of Systems:

Constitutional:

Yes	No	
☐	☐	Fever
☐	☐	Chills
☐	☐	Weight gain
☐	☐	Weight loss
☐	☐	Fatigue
☐	☐	Trouble sleeping

Cardiovascular:

Yes	No	
☐	☐	Chest pain
☐	☐	Leg/feet swelling
☐	☐	Irregular heartbeats
☐	☐	High blood pressure
☐	☐	Heart attack
☐	☐	Heart Murmur

Gastrointestinal:

Yes	No	
☐	☐	Colon polyps
☐	☐	Abdominal pain
☐	☐	Bright red blood in stools
☐	☐	Black stools
☐	☐	Trouble swallowing
☐	☐	Heartburn
☐	☐	Change in appetite
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Nausea
☐	☐	Vomiting

Eyes/Ears/Nose/Throat:

Yes	No	
☐	☐	Ringing in Ears
☐	☐	Hearing Loss
☐	☐	Vision Loss
☐	☐	Sore Throat

Neurological:

Yes	No	
☐	☐	Headache
☐	☐	Stroke
☐	☐	Seizure
☐	☐	Dizziness
☐	☐	Numbness
☐	☐	Tingling

Genitourinary:

Yes	No	
☐	☐	Frequent urinary tract infections
☐	☐	Frequent urination
☐	☐	Burning with urination
☐	☐	Incontinence of urine
☐	☐	Kidney Stones

Psychiatric:

Yes	No	
☐	☐	Sleep problems
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Chemical dependency
☐	☐	Memory problems

Respiratory:

Yes	No	
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Wheezing

Hematologic/Oncologic:

Yes	No	
☐	☐	Anemia
☐	☐	Abnormal bleeding/Bruising
☐	☐	Blood clots

Musculoskeletal:

Yes	No	
☐	☐	Gout
☐	☐	Stiffness
☐	☐	Joint swelling
☐	☐	Muscle weakness
☐	☐	Back pain
☐	☐	Pain
☐	☐	Arthritis

Endocrine:

Yes	No	
☐	☐	Diabetes
☐	☐	Chronic kidney disease
☐	☐	Thyroid disorder
☐	☐	Abnormal growth

Skin:

Yes	No	
☐	☐	Rashes
☐	☐	Itching
☐	☐	Open sore