**New Patient Intake Form**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Birth: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Current Age: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Weight: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Height: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Right-handed, left-handed or ambidextrous (circle best option or options)

**Reason for Today’s Appointment:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Names and relationships of others accompanying patient to today's visit:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Referring Physician**, Address and Phone**:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician or Provider**, Address and Phone:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Physicians or Providers** (Names, Specialties)**:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Pharmacy** (local) (Name, Address, Phone):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy** (mail order) (Name, Address, Phone):

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**Medical Conditions:**

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**Surgical History:**

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**Trauma/Accident History:**

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**Medications** (Name, Dose, Frequency):

Please include OTC (Over The Counter) medications and supplements

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**ALLERGIES and ADVERSE DRUG REACTIONS** (Medication name, reaction if known):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:** (parents, siblings, children – deceased or living?, known medical issues? pt adopted? family members adopted? half-siblings? extended family – known medical issues and relationship to pt? any family with symptoms conditions similar to patient’s issues and relationship to pt)

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**Heritage/Ancestries** (if known)**:**

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**Social History:**

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living with or at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe at home? NO / YES (circle answer)

Children (NO / YES , number, ages) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation (profession, retirement, disability, part time work, school):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of Education:

\_ Less than 12 (if so, how many years \_\_\_\_)

\_\_ 12 – high school

\_\_ 16 college

\_\_ 17-20 post grad work

\_\_ 20+ more than 20):

Degrees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Habits: (circle appropriate yes or no response)

Tobacco use, current – NO / YES. Amt per day \_\_\_\_\_\_\_, type \_\_\_\_\_\_\_\_, number of years \_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use, past only – NO / YES, Amt per day \_\_\_\_\_ , type \_\_\_\_\_\_\_\_, number of years \_\_\_\_\_\_\_\_\_\_\_\_, when stopped \_\_\_\_\_\_\_\_\_\_\_

Alcohol use, current NO / YES, Amt per day \_\_\_\_\_\_, type \_\_\_\_\_\_\_\_, number of years \_\_\_\_\_\_\_\_\_\_\_\_\_\_, Any concerns NO / YES

Alcohol use, past only – NO / YES, Amt per day \_\_\_\_\_\_, type \_\_\_\_\_\_\_, when started \_\_\_\_\_\_\_\_, when stopped \_\_\_\_\_\_\_\_\_\_\_\_

Recreational or non prescription drugs, current – NO / YES. Amt per day \_\_\_\_\_\_, type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, number of years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational or non prescription drugs, past – NO / YES, Amt per day \_\_\_\_\_\_\_\_<

 type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, when started \_\_\_\_\_\_\_\_\_, when stopped \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CBD NO / YES, If yes, reason for use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, type(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, amt per day \_\_\_\_\_\_\_\_\_, results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical marijuana – NO / YES – If yes reason for use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, amt per day \_\_\_\_\_\_\_\_\_, results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeinated beverages NO / YES. If yes, average amt per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular exercise NO / YES If yes, amt \_\_\_\_\_\_\_\_\_\_\_, frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone replacement therapy, Present NO / YES, if yes – type:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone replacement therapy, Past NO / YES, if yes what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For females only :*

*Are you or could you be pregnant – NO / YES*

*Age at first full term pregnancy –*

*Any past miscarriages? y/n*

*Age at first menstrual period –*

*Age at last menstrual period –*

*History of oral contraceptives? – NO / YES*

**Pain:**

Do you experience pain as part of your daily life? NO / YES

If yes, please describe location(s), onset, duration and characteristics of your pain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, on a scale of 1-10 (0= no pain and 10 = the worst pain) how would you rate your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Proxy:**

Do you have a health care proxy (circle one): NO / YES

If yes, please list name of proxy and contact information. Please also bring copy of documents for files

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If no, and you would like more information, please speak with provider at appointment

**Living Will:**

Do you have a living will: NO / YES

If yes, please bring copies of documents for file

**Patient name** (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient signature and date of completion:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

**Patient legal representative or guardian name** (printed):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient legal representative or guardian signature and date of completion:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_