Intake Form

Date:

Personal Information

- Full Name: ______________________________
- Date of Birth (MM/DD/YYYY): ______________
- Gender: ________________________________
- Contact Number: ________________________
- Email Address: __________________________
- Home Address: __________________________

Emergency Contact Information

- Name: ________________________________
- Relationship to Patient: ________________
- Contact Number: ________________________

Insurance Information: Please provide photo of front & back of ins. card

- Insurance Provider: _____________________
- Policy Number: __________________________
- Group Number: __________________________

Medical History

- **Do you have any known allergies?**
  - Yes No
  - If yes, please list medication(s)/food(s) and type of reaction:
  - _______________________
  - _______________________
  - _______________________
- **Current Medication(s), Dosage and Frequency:**
  - _______________________

- ____________________________
- ____________________________
- ____________________________

- **Past Surgeries or Hospitalizations:**
  - ____________________________
  - ____________________________
  - ____________________________
- **Family History**

Please list family members (their relation to you) + health conditions (i.e high blood pressure, cancer, autoimmune disease, thyroid disease, anxiety, depression, cardiac diseases (MI, heart failure), stroke.

Please note if they are living and if so, what age, if deceased, how old were they?:

Relationship to patient Condition Living? Age?

____________________________ ____________________________ ________________

____________________________ ____________________________ ________________

____________________________ ____________________________ ________________

____________________________ ____________________________ ________________

Do you have any chronic or current health conditions?

Yes No

If yes, please list:

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Other healthcare providers or specialists involved in your care?

Please list names and telephone and/or address of providers:

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Lifestyle and Habits

Do you smoke or vape? If yes, please describe (i.e : tobacco, nicotine, cannabis)

Yes No

Do you consume alcohol? Estimated drinks per week:

Yes No

Exercise Frequency:

None Occasionally Regularly

Do you have a history of substance abuse? If yes, please provide details and whether you received treatment or use is ongoing. If you have a history of taking more prescription medication than prescribed, please list medication and average doses taken:

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Preferred Pharmacy

- Name of Pharmacy: ________________________
- Phone Number: ______________________________
- Address or Crossroads and Zip Code: ______________________________

Reason for Visit

Please describe the reason for your visit, any health goals or concerns you have:

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Consent and Signature

I hereby authorize the medical staff to provide necessary medical treatment and share relevant information with my insurance provider.

Name (Printed): __________________________

Signature: ________________________________

Date: ____________________________________