

PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Axilix Medical .
This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ **Last Name**: _____

Date of Birth: _____ **Gender**: ◯ Male ◯ Female ◯ Other

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Mobile Phone**: _____

Social Security Number: _____ **E-Mail**: _____

Ethnicity/Race: _____ **Weight**: _____ **Height**: _____

Primary Language: ◯ English ◯ Spanish ◯ Other: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Spouse Name: _____ **Spouse Phone**: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **E-Mail**: _____

Home Phone: _____ **Mobile Phone**: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***not*** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ **ID #**: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are ***not*** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth**: _____

Policyholder Social Security Number: _____

TREATING PHYSICIANS

Primary Care Physician: _____ **Phone**: _____

List all other active treating physicians:

Physician Name: _____ **Specialty**: _____

Physician Name: _____ **Specialty**: _____

Physician Name: _____ **Specialty**: _____

Physician Name: _____ **Specialty**: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	
Other:		☐ Y ☐ N	

SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description	Doctor	Location	Year

MEDICAL HISTORY

Have you ever had any of the following?

Anemia	◯Y◯N	Hypertension	◯Y◯N
Arthritis Conditions	◯Y◯N	Male Hypogonadism	◯Y◯N
Asthma	◯Y◯N	Hypothyroidism	◯Y◯N
Atrial Fibrillation	◯Y◯N	Infection Problems	◯Y◯N
Bleeding Problems	◯Y◯N	Insomnia	◯Y◯N
Benign Prostatic Hyperplasia	◯Y◯N	Irritable Bowel Syndrome	◯Y◯N
Coronary Artery Disease	◯Y◯N	Kidney Problems	◯Y◯N
Cancer	◯Y◯N	Menopause	◯Y◯N
Cardiac Arrest	◯Y◯N	Migraines/Headaches	◯Y◯N
Celiac Disease	◯Y◯N	Neuropathy	◯Y◯N
Chest Pain	◯Y◯N	Onychomycosis	◯Y◯N
Congestive Heart Failure	◯Y◯N	Organ Injury	◯Y◯N
Chronic Fatigue Syndrome	◯Y◯N	Osteoporosis	◯Y◯N
Depression	◯Y◯N	Pulmonary Embolism	◯Y◯N
Diabetes	◯Y◯N	Seizure Disorders	◯Y◯N
Drug/Alcohol Abuse	◯Y◯N	Shortness of Breath	◯Y◯N
Erectile Dysfunction	◯Y◯N	Sinus Conditions	◯Y◯N
Fibromyalgia	◯Y◯N	Stroke	◯Y◯N
Gerd	◯Y◯N	Syndrome X	◯Y◯N
Heart Disease	◯Y◯N	Tremors	◯Y◯N
Hyperinsulinemia	◯Y◯N	Wheat Allergy	◯Y◯N
Hyperlipidemia	◯Y◯N		

List any other medical problems that you have had:

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? ◯Yes ◯No

- If so, where? _____

How has the pain changed since it began? ◯Increased ◯Decreased ◯Unchanged

How quickly did you current pain begin? ◯ Gradually ◯ Suddenly

How often does your pain occur? ◯ Constantly ◯ Occasionally ◯ Rarely

When is your pain at its worst? ◯ Morning ◯ Afternoon ◯ Evening ◯ Night

What are your current symptoms? _____

Check any of the following that describe your pain:

Aching ☐	Numbness ☐	Spasming ☐	Throbbing ☐
Cramping ☐	Shock-like ☐	Squeezing ☐	Tingling ☐
Dull ☐	Shooting ☐	Stabbing/Sharp ☐	Tiring/Exhausting ☐
Hot/Burning ☐			

List any other health concerns that you would like us to know about:

SOCIAL HISTORY

Do you currently consume alcohol? ◯ Yes ◯ No

- How many drinks per week? _____

Do you currently smoke? ◯ Yes ◯ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? ◯ Yes ◯ No

- What other drugs do you take? _____
- How often? ◯ Daily ◯ Weekly ◯ Occasionally ◯ Rarely

Do you drink caffeine? ◯ Yes ◯ No

- How many cups per day? _____

Are you sexually active? ◯ Yes ◯ No

Would you like to be checked for STIs? ◯ Yes ◯ No

How frequently do you exercise? ◯ Daily ◯ Weekly ◯ Occasionally ◯ Rarely

Are you on a special diet? ◯ Yes ◯ No

- What diet? _____

Complete the following if applicable:

Are you planning a pregnancy? ◯ Yes ◯ No

Are you pregnant now? ◯ Yes ◯ No

What type of contraception do you currently use? _____

When was your last menstrual cycle? _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____