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New Patient Intake

Patient Information:

Name:_____DOB:_____

Address_____SS Number:_____

Phone_____Email_____

Spouse/Significant Other:_____ Phone_____

Children:_____

Employment:

Company:_____Phone_____

Insurance:

Insurance Provider:_____Member ID:_____

Group Number:_____Primary Subscriber Name:_____

Primary Subscriber DOB:_____

Insurance Co. Address (on back of card):_____

Preferred Pharmacy:_____

Allergies:_____

Current Medications: _____

_____

_____

Current Supplements: _____

_____

Please list your current health Concerns:

_____

_____

_____

Past Surgical History with Dates:

_____

_____

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Personal History/Review of Systems:

General: Fatigue_____ Weight Change_____ Frequent Infections_____ Migraines _____

Respiratory: Asthma_____ COPD_____ Allergies_____ Seasonal Allergies _____

Cardiovascular: High BP_____ Chest pain_____ Irregular HR_____ High cholesterol_____

History of Blood Clots/Blood Disorders_____

Gastrointestinal: Constipation_____ Loose Bowels_____ Gas/bloating_____ Heartburn_____

Urinary: Hx of frequent UTIs_____ Incontinence_____ Blood in urine_____

Muscular/Skeletal: Joint pain_____ Muscular pain_____Stiffness/swelling_____

Numbness/Tingling_____

Females:

Gynecological: Abnormal pap_____Irregular cycles_____Heavy flow_____ Spotting_____

Frequent yeast infections_____ Vaginal discharge_____Vaginal dryness_____

Gynecology (females) : Pregnancies _____ Vaginal delivery_____C- section_____

Miscarriage/Abortion_____

Birth Control_____ Method/Medication Name_____

Do you currently, or have you ever used tobacco?_____

How long_____ How much/day_____

Do you currently consume alcohol?_____How much?_____

Do you use any recreational substances (e.g.marijuana, cocaine, etc)?_____

Frequency_____

Family History:

Please indicate the following: M=Mother F=Father S=Sister(s) B=Brother(s) G=Grandparent(s)

Blood Disorders_____ Anemia_____

Alcohol/Drug Abuse_____

Cancer_____Type:Colon_____Breast_____Lung_____Other_____

Diabetes_____Thyroid Disorder_____Other Autoimmune Disease_____

Heart Disease:_____ High Blood Pressure_____ High Cholesterol_____

Mental Illness_____ Suicide_____ Dementia_____