# Patient Intake Form

***Please fill in all the information as accurately as possible.*** The information you provide will assist in formulating a complete health profile. All Answers are confidential.

## PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Sex ____ Marital Status _____ Email Address _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (  )_____ Cell Phone (  )_____ Work Phone (  )_____

## EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (  )_____ Cell Phone (  )_____ Work Phone (  )_____

Name _____ Relationship _____

Home Phone (  )_____ Cell Phone (  )_____ Work Phone (  )_____

## INSURANCE INFORMATION

Insurance Carrier _____ Insurance Plan _____

Contact Number _____ Policy Number _____

Group Number _____ Social Security Number _____

## REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care? Yes ☐ No ☐ For? _____

Primary Care Physician _____

## HEALTH CONCERNS/SYMPTOMS

Describe your main concerns (symptoms, onset, diagnoses, duration, etc.)

_____

_____

_____

_____

When did your chief problem or illness begin? _____

What are your goals for today's visit and for your long-term health?

_____

_____