Patient Intake Form

First Name	Middle Name	Last Name

Date of Birth	Social Security #	Driver's License #

Email Address	Mobile Number	Alternate Number

Do we have your consent to contact you via email, text, or phone call? yes

Physical Address:

Medical History

Allergies

Medication Allergies	
Food Allergies	
Environmental Allergens	

Current Medications

Social History

Do you currently or previously used tobacco products?

YES	NO

If yes, what products do you use?

Frequency of use:

If you no longer use tobacco products, when did you quit?

Do you currently consume alcohol?

YES	NO

How often do you consume alcohol?

DAILY	WEEKLY	SOCIALLY	RARELY

In the past year have you consumed any illicit drugs?

YES	NO

If yes, please describe:

Highest level of education completed:

What is your current occupation?

Activities of daily living

Are you able to care for yourself?

YES	NO

Do you have a visual impairment?

YES	NO

Do you have a hearing impairment?

YES	NO

Do you have difficulty concentrating, remembering, or making decisions?

YES	NO

Do you have difficulty walking short distances?

YES	NO

Do you have difficulty climbing stairs?

YES	NO

Do you have difficulty dressing or bathing?

YES	NO

Do you have trouble with transportation?

YES	NO

Past Medical History

Family Medical History:

Disease	Relative	Disease	Relative
Alzheimer's		Glaucoma	
Arthritis		Parkingson's	
Asthma/COPD		Ulcerative Colitis	
Anemia		Crohn's Disease	
CVA(stroke)		Lupus	
Congenital disorder		Schizophrenia	
Cancer		Bipolar Disorder	
Diabetes		OCD Disorder	
Hypertension		Addiction	
Heart Disease		Mental Disorder	
Kidney Disease		Other	

Previous Medical History:

ADD/ADHD		Ulcerative Colitis		
Autism		IBS		
Abuse		Migraines		
Allergies		Hepatitis		
Anemia		HIV/AIDS		
Sickle Cell Disease		Hypertension		
Anxiety		Thyroid disease		
Arthritis		Infertility		
Asthma		Endometriosis		
Birth Defects		Meniere's Disease		
Bladder/Kidney problems		Kidney Disease		
Blood Disease		Drug Addiction		
Blood Transfusion		Alcohol Addiction		
Cancer		Osteoporosis		
COPD		Fibromyalgia		
Heart failure		Degenerative Disc Disease		
High cholesterol		Gout		
Diabetes		Seizures		
Depression		GERD		
ALS		Spinal Cord Injury		
Crohn’s Disease		Glaucoma		
Muscular Dystrophy		Mental Health Disorder		

Surgical History:

Previous Surgeries	Date

Are you currently pregnant or planning to become pregnant?

Are you at least 26 years of age?

Are you a current Mississippi resident?