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INITIAL VISIT PATIENT INTAKE FORM

Date: ___________________

Name: ____ **Date of Birth:** _____________________
Address: _____________________________________ **Apt#:** ________ **City:** ________ **State:** _______ **Zip:** ______
Home#: (___)___________________ **Work#:** (___)___________________ **Cell#:** (___)___________________
Social Security #: ____
Referring Physician: ________________________________ **Primary Physician:** _____________________________
Patient Notification will be done by e-mail (please provide your e-mail address here): ________________________
I authorize the use of the above e-mail: ____ _______________
Patient Signature Date

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported
Language: ☐ English ☐ Spanish ☐ Other: ____
Local Pharmacy: ____
(Name/City/Phone #)
Mail Order Pharmacy: ____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: ____
Timing/Onset: When did symptoms first occur? ____
Duration: Frequency of symptoms? ____
Characterized as/Severity: Describe the severity of the symptoms/pain. ______________________________________

Associated Signs and Symptoms: Are there any other symptoms associated with your problem?___________________
____
Modifying Factors: What makes the condition better and/or worse? ____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?
☐ Anxiety ☐ Cancer ☐ Heart Disease ☐ History of Carotid Dis. ☐ Seizure Disorder
☐ Arthritis ☐ Depression ☐ High Blood Pressure ☐ Migraines ☐ Stroke
☐ Back Pain ☐ Diabetes ☐ High Cholesterol ☐ Neck Pain ☐ Thyroid Disease
☐ Other: ____
____
____
____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	Name of Medication	Dosage

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

☐ Acetaminophen ☐ Aspirin ☐ Dilantin ☐ Imaging Contrast ☐ Penicillin ☐ Sulfa Drugs

____ Other: ____

____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Alzheimer's Disease						
Aneurysm						
Autoimmune Disorders						
Bleeding Disorder						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Multiple Sclerosis						
Parkinson's Disease						
Stroke						
Seizure Disorder						
Tremors						

Other: ____

____

____

PAST SURGICAL HISTORY:

List significant surgeries or injuries (Write “None” if you have no past surgeries or injuries):

☐ Cardiac Pacemaker ☐ Coronary Artery Bypass Graft ☐ Craniotomy ☐ Spinal Fusion
☐ Carotid Surgery/Stent ☐ Craniotomy ☐ Discectomy

Surgeries/Injuries	*Date(s) or Age/Surgeon*

SOCIAL HISTORY:

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

Most Recent Primary Occupation: ☐ None ☐ Other: ____________________

Highest Education Level Attained: ☐ Less than High School ☐ High School Graduate ☐ Some College
☐ College Graduate ☐ Postgraduate ☐ Unknown

Please describe your Current Tobacco Use?
☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Never ☐ Occasionally ☐ Frequently

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, please indicate what type of beverage and how many servings per day: ____________________

Have you ever used any illicit drugs? ☐ Yes ☐ No
If yes, please indicate what type of drug and how often: ____________________

Please describe your current exercise routine: ☐ Inactive ☐ Light ☐ Moderate ☐ Heavy

Comments: ____________________

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:
- ❑ Fatigue
- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss

Skin:
- ❑ Excessive Sweating
- ❑ Rash

HEENT:
- ❑ Sleep Apnea
- ❑ Facial numbness/tingling

Neck:
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Swelling

Respiratory:
- ❑ Difficulty Breathing
- ❑ Snoring
- ❑ Wheezing

Cardiovascular:
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Swelling of Extremities

Gastrointestinal:
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty Swallowing
- ❑ Nausea
- ❑ Vomiting

Genitourinary:
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Urgency

Musculoskeletal:
- ❑ Back Pain
- ❑ Decreased Range of Motion
- ❑ Joint Pain
- ❑ Muscle Pain
- ❑ Muscle Weakness

Psychiatric:
- ❑ Apathy
- ❑ Anxiety
- ❑ Change in Sleep Pattern
- ❑ Depression
- ❑ Hallucinations
- ❑ Nervousness
- ❑ Panic Attacks
- ❑ Trouble Falling Asleep

Endocrine/Glands:
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Sexual Dysfunction
- ❑ Thyroid Problem

Hematology:
- ❑ Abnormal Bleeding
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Painful Lymph Nodes

Neurological:
- ❑ Auras
- ❑ Balance Problems
- ❑ Decreased Memory
- ❑ Difficulty Speaking
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Frequent Falls
- ❑ Headaches
- ❑ Incoordination
- ❑ Numbness/Tingling
- ❑ Paralysis
- ❑ Seizures
- ❑ Stroke
- ❑ Tremor
- ❑ Trouble Walking
- ❑ Vertigo
- ❑ Visual Changes
- ❑ Weakness

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this practice of any changes in my medical status.

Signature: ____