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?

_____

_____