

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?
