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.)

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When did your chief problem or illness begin? ____________

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

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