**Patient Intake Form**

**Patient Name:** ____________________ **DOB:** __________ **Age:** __________

**Address:** ______________________________________________

**City:** ______________ **State:** _____ **Zip:**_______ **Cell Phone:** ____________________

**Home Phone:** ________________ **Work Phone:** ________________

☐ **OK to send Text** ☐ **Ok to leave Voice Message** ☐ **OK to email** **Email Address:** ________________

**Gender: M F** **Weight:** ________ **Height:** __________

**Spouse's (or parent if patient is minor) name:** ______________________________

**How did you hear about us?** ______________________________

**Whom May We Contact in Case of Emergency?** ______________________________

**Phone:** ________________ **Relationship:** ________________

**List in order of Importance what your health problems are:**

**1.** ____________________ **4.** ____________________

**2.** ____________________ **5.** ____________________

**3.** ____________________ **6.** ____________________

**Last time you had blood work done and with what physician:** ______________________________

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**Current Medications/Supplements:** ______________________________

______________________________________________

**Are you allergic to any medications or food?** ☐ **No** ☐ **Yes** ______________________________

**Symptoms (check all that apply):**

| | | |
|---|---|---|
| ☐ **Allergies** | ☐ **Diarrhea** | ☐ **Joint Pain** |
| ☐ **Angina** | ☐ **Dizziness** | ☐ **Overweight** |
| ☐ **Anxiety** | ☐ **Fatigue** | ☐ **Recurrent Infections** |
| ☐ **Back Pain** | ☐ **Headaches** | ☐ **Shortness of Breath** |
| ☐ **Bloating** | ☐ **High Blood Pressure** | ☐ **Ulcers** |
| ☐ **Constipation** | ☐ **Hot Flashes** | ☐ **Weight Loss** |
| ☐ **Depression** | ☐ **Irregular Heartbeat** | |

**List all Surgeries & Hospitalizations, Including date occurred:**

1. ________________________________________ 4. ________________________________________
2. ________________________________________ 5. ________________________________________
3. ________________________________________ 6. ________________________________________

**Please Note When and Why You Have Had Each of the Following:**

**X-Rays:** __________________________________ **HIV Test:**_________________________________

**Ultrasounds:**______________________________ **HCV Test:** ________________________________

**MRI/CT Scan:** _____________________________ **Last Eye Exam:** ____________________________

**Accidents:** ________________________________ **Last Dental Exam:**______________________

**TB Test:**__________________________________

**Lifestyle:**

**Exercise (times/week):** ________________ **Type:** ______________________________________________________________

**Hours of Sleep per night:** ______________ **☐Trouble Falling Asleep?** **☐Trouble Staying Asleep?**

**Glasses of water/day:** ________________ **Do you drink/ how much: ☐Soda** _____________ **☐Coffee** ________________

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**Family History**

| | Father | Mother | Siblings | Grandparents | Children |
|---|---|---|---|---|---|
| **Age if living** | ______ | ______ | ______ | ______ | ______ |
| **Age when died:** | ______ | ______ | ______ | ______ | ______ |
| **Reason for Death:** | ______ | ______ | ______ | ______ | ______ |
| **Cancer type:** | ______ | ______ | ______ | ______ | ______ |
| **High Blood Pressure:** | Y N | Y N | Y N | Y N | Y N |
| **Heart Attack/Stroke** | Y N | Y N | Y N | Y N | Y N |
| **Heart disease:** | Y N | Y N | Y N | Y N | Y N |
| **Asthma/Allergies:** | Y N | Y N | Y N | Y N | Y N |
| **Mental Illness:** | Y N | Y N | Y N | Y N | Y N |
| **TB** | Y N | Y N | Y N | Y N | Y N |
| **Auto-Immune Disease:** | Y N | Y N | Y N | Y N | Y N |
| **Osteoporosis** | Y N | Y N | Y N | Y N | Y N |