Patient Intake Form

Date of Visit		Administrator Name	
		Administrator ID No.	
First Time Visit	Y/N	Referring Care Provider	
Primary Care Provider			
Primary Care Contact Information			

Patient Information

Full Name		Date of Birth	
Preferred Name		Social Security Number	
Legal Sex		Gender Identity	
Primary Address		Email	
Contact Number		Secondary Contact Number	
Occupation		Employment Status	

Emergency Contact Name		Emergency Contact Number	
Relationship		Email	

Insurance Information

Insurance Carrier		Group Number	
Name of Insured		Policy Number	

Patient Date of Birth		Patient Signature	

Health Concerns and Symptoms

What is the reason for your visit? Are you currently experiencing any symptoms?
When did your symptoms or illness begin? Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.
Do you have any previous or ongoing physical or mental health conditions?

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

Are you currently undergoing any medical treatment?

Y/N	If yes, specify treatment:

Are you currently taking any medication?

Y/N	If yes, specify medication:

Have you recently undergone any surgical procedures?	
Y/N	If yes, specify surgeries:
Date of Last Physical Examination:	
Additional Notes	