**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 |
|  |

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**Online Patient Intake Forms**

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