



Patient Intake Form

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Age: _____ Male or Female: _____ Social Security #: _____

Home Address: _____

Street

City

State

Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Primary Language Spoken: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Referring Doctor: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse Name: _____ Date of Birth: _____

Primary Insurance

Insurance Co: _____ Policy # _____ Group # _____

Subscribers Name: _____ SS# _____ DOB _____

Address if Different than Patient: _____ Phone: _____ Relationship to Patient: _____

Street

City

State

Zip

Secondary Insurance

Insurance Co: _____ Policy # _____ Group # _____

Subscribers Name: _____ SS# _____ DOB _____

Address if Different than Patient: _____ Phone: _____ Relationship to Patient: _____

Street

City

State

Zip

Emergency Contact (EC) / Release of Information (ROI)- Please Check the Boxes that Apply:

Name of Person to Contact in case of Emergency/ or we may release information to:

Name: _____ Phone: _____ Relationship: _____ ☐ EC ☐

ROI Name: _____ Phone: _____ Relationship: _____ ☐ EC

☐ ROI Name: _____ Phone: _____ Relationship: _____ ☐ EC

☐ ROI

Communication: ☐ Message may be left ☐ Answering Machine ☐ Family Member _____ **Living**

Will? ☐ N ☐ Y **Durable Power of Attorney?** ☐ N ☐ Y (if yes) Name: _____

Phone: _____

Relationship: _____

Print: _____ Signature: _____ Date: _____



Patient Initials: _____ DOB: _____ Height: _____ Weight: _____ lbs

Current Symptoms/ Reason for Visit :

Length of time:

1.	
2.	
3.	

Are your Symptoms?

	Yes	No	When
Work Related?	_____	_____	_____
Injury Related?	_____	_____	_____
Did you stop working?	_____	_____	_____
Did you return?	_____	_____	_____

Recent Testing? (Last 6 Months) ☐ No ☐ Yes

Test Name

Date

1.	
2.	
3.	

Current Symptoms: Please Check All that Apply

- | | | |
|---|---|--|
| ☐ Abdominal Pain | ☐ Frequent Urination | ☐ Nosebleeds |
| ☐ Back Pain | ☐ Hair Loss | ☐ Numbness/ Tingling |
| ☐ Blood in Urine | ☐ Headaches | ☐ Pain/ Bleeding during Sex |
| ☐ Bloody/ tarry stool | ☐ Hemorrhoids | ☐ Painful Urination |
| ☐ Bruise Easily | ☐ Hernia | ☐ Phobias |
| ☐ Change in bowel habits | ☐ Hives | ☐ Rashes |
| ☐ Chest Pain | ☐ Hoarseness | ☐ Ringing in Ears |
| ☐ Cold numb feet | ☐ Indigestion/ Heartburn | ☐ Sexual Dysfunction |
| ☐ Constipation | ☐ Insomnia | ☐ Shortness of Breath |
| ☐ Convulsions/ Seizures | ☐ Joint Pain | ☐ Sinus Trouble |
| ☐ Cough | ☐ Leg Pain | ☐ Sore Throat |
| ☐ Diarrhea | ☐ Loss of Appetite | ☐ Swollen Ankles |
| ☐ Difficulty Swallowing | ☐ Lumps/ Masses | ☐ Tooth/ Gum Trouble |
| ☐ Dizziness/ Fainting | ☐ Memory Loss | ☐ Tremors |
| ☐ Ear Infection | ☐ Moodiness | ☐ Urethral Discharge |
| ☐ Failing Vision | ☐ Muscle Weakness | ☐ Varicose Veins |
| ☐ Fatigue | ☐ Nausea/ Vomiting | ☐ Weight Loss |
| ☐ Fever | ☐ Nervousness | |
| ☐ Foot Pain | ☐ Night Sweats | |



Patient Initials: _____ DOB: _____

Previous Surgery

Hospital

Date

Problems with Anesthesia in the past? ☐N ☐Y-Explain _____

Do you have a Pacemaker? ☐N ☐Y

Please list any serious injuries: _____

Family History

Illness

Deceased Living

Father			
Mother			
Brother			
Sister			
Children			
Other			

Social History

Do you live alone? ☐Y ☐N- who? _____

Number of Children- _____

Do you exercise regularly? ☐Y ☐N

Which is your Dominant Hand? ☐Right ☐Left

Highest grade level completed? _____

Occupation? _____

Are you on a special diet? _____

Do you use any of the following- Please check all that apply

	Yes	Never	Quit	Amount per Day
Recreational Drugs				
Alcohol				
Tobacco				
Caffeine				

Please complete if applicable:

Are you planning a pregnancy? ☐Y ☐N

What kind of contraception are you using currently?

_____ Are you pregnant now? ☐Y ☐N

When was your last menstrual cycle? _____

RESTORATIVE
MEDICINE & WELLNESS, PLLC

Patient Initials:_____ **DOB:**_____

Patient Medical History		Yes	No	Yes	No	Yes	No

AIDS		Eczema		Multiple Sclerosis		
Anemia		Emphysema		Mumps		
Anxiety		Epilepsy		Muscle Disorder		
Arrhythmia		Eye/ Ear Disorder		Neuropathy		
Arthritis		Genetic Defects		Osteoporosis		
Asthma		Gout		Parkinson's Disease		
Birth Defect: _____		Hayfever/ Allergies		Phlebitis		
Blood Disorder/ Clot		Heart Attack		Pneumonia		
Bone/ Joint Disorder		Heart Disease		Polio		
Bronchitis		Heart Murmur		Prostate Disease		
Cancer: Type _____		Hepatitis: Type _____		Psoriasis		
Chicken Pox		Herpes		Rubella		
Cirrhosis/ Liver		High Blood Pressure		Seizures		
Colitis		Jaundice		Skin Disease		
Congestive Heart Failure		Kidney Failure		Sleep Apnea		
COPD		Kidney Stones		Stroke		
Crohn's Disease		Lactose Intolerant		Tetanus		
Deep Vein Thrombosis		Low Blood Pressure		Thyroid Disease		
Depression		Lung Disease		Tuberculosis		
Diabetes		Measles		Ulcers		
Diphtheria		Mental Illness		Venereal Disease		
Diverticulosis		Migraines		Other: _____		

Local Pharmacy: _____ **Mail In:** _____

Current Medications	Dose	Frequency
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[illegible]Allergies to Medication? ☐ No ☐ Yes

List: _____

Latex Allergy? ☐N ☐Y

Metal Allergy? ☐N ☐Y