Patient Intake- Standard Insurance

1. Please enter your information.

First Name: ____ Middle Initials: ____ Last Name: ____ Date of Birth: ____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Mobile Phone: ____ Home Phone: ____ Work Phone: ____

Email: ____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Ethnicity
☐ Caucasian ☐ Hispanic ☐ African-American ☐ Asian ☐ Decline to Specify

Language Preference
☐ English ☐ Spanish ☐ Polish ☐ Other

How did you hear about CHPT?
____

What is your primary reason for your visit today?
____

When did your symptoms begin?
____

Emergency Contact ____ Emergency Contact Phone ____

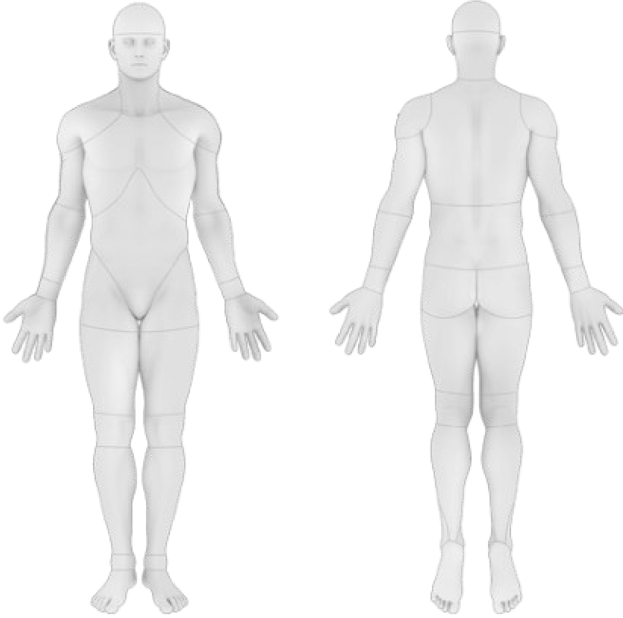
Your Occupation (if applicable)
____

2. Current complaint

Please describe:
____

0 - Not difficult / 10 - Unbearable
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

3. Please mark the body part(s) of concern:



4. Have you seen a physician or other health practitioner about this? If 'yes', when? What was the diagnosis (if any)?

____
____
____
____

5. Have you had any serious conditions, illnesses, and/or injuries in the past 5 years? If 'yes', please list approximate dates.

____
____
____
____

6. How often are you having pain or discomfort?

- ○ Less than once per week
- ○ Several times per week
- ○ Once a day
- ○ Several times per day
- ○ Most of the time

7. Please list any prescribed medications you take:

	Name	Dosage	How long?
1			
2			

8. Please list all non-prescription medications you take:

	Name	Dosage	How long?
1			
2			

9. Do you have any allergies (medicines, cosmetics, environmental, foods)? If 'yes', please describe.

10. Have you been diagnosed with any of the following conditions?

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart condition
- ☐ Cancer
- ☐ Bleeding disorder
- ☐ Thyroid condition
- ☐ Irritable bowel
- ☐ Ulcerative colitis
- ☐ Liver disease
- ☐ Asthma
- ☐ HIV / AIDS
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Kidney disease
- ☐ Cardiovascular disease
- ☐ Other(s)

If "other(s)", please specify

11. Have you had any surgeries and/or hospitalizations the doctor should be aware of? If 'yes', please list approximate dates.

12. Habits and Lifestyle

Do you smoke? ☐ Yes ☐ No | If 'yes', what? | How much per day? | Since when?

Do you drink alcohol? ☐ Yes ☐ No | If 'yes', what? | How much? | How often?

Do you drink soda pop? ☐ Yes ☐ No | If 'yes', what type? ○ Regular ○ Diet | How much? | How often?

Do you exercise regularly? ☐ Yes ☐ No | If 'yes', please describe what you do.

13. Current emotional stress scale:

0 - No stress / 10 - Extremely stressed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10