Patient Intake

Standard Insurance/Medicare and Self Pay

1. **Please enter your information. Make sure you provide your legal name.**

Name:

DOB:

Gender:

__ Male __ Non-Binary __ I prefer not to say

__ Female __ Transgender

Marital Status:

__ Single __ Married ___ Domestic Partner __ Separated __ Divorced __ Widowed

Street Address: ____

Mobile Phone: ___________ Home Phone: ____________ Work Phone: __________

Email: ____________________________________

Preferred Contact Method:

___ Mobile phone ___ Home Phone ___ Work Phone ___ Email

Race:

___ White ___ Black ____ Asian ___ Hispanic ___ Decline to answer

Language Preference:

___ English ___ Spanish ___ Polish ___ Other (please specify: ________)

How did you hear about CHPT? We'd love to thank them! ___________________________

What is your primary reason for your visit today? _________________________________

When did your symptoms begin? ____

Emergency Contact Name: ____________________________

Emergency Contact Phone: ____________________________

Your occupation (if applicable): _________________________

2. **Please upload a picture of your ID (Federal or State ID, passport, etc.) on your AdvancedMD patient portal.**

3. **If using insurance, please upload a photo of front and back of your insurance card on your AdvancedMD patient portal.**

4. **Current complaint:**

   Please describe your symptoms, including the location:

   Pain level (0 Not difficult/10 Unbearable): __ 0 __ 1 __ 2 __ 3 __ 4 __5 __ 6 __7 __8 __9 __10

   Describe the pain characteristics (check as many as appropriate):

   __ Ache __ Burning __ Dull __ Sharp __ Throbbing

   Pain Radiates Into (check as many as appropriate):

   __ Does Not Radiate __Arm-Right __ Arm-Left __ Back-Upper __ Back-Lower

   __ Hand-Right __Hand-Left __Leg-Right __Leg-Left __Foot-Right __Foot-Left

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

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6. **Please list your primary care physician or the provider who referred you here today:**

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

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8. **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

9. **Please list any prescribed medications you take (Name, Dosage, how long)**

   1. ____

   2. ____

10. **Please list all non-prescription medications you take (Name, Dosage, how long)**

    1. ____

    2. ____

11. **Do you have any allergies (medicines, cometics, environmental, foods)? If yes, please describe:**

____

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

___ Diabetes ___ Epilepsy ___ Heart Condition ___ Asthma ___ Cancer

__ Bleeding disorder ___ Thyroid condition ___ Irritable bowel __ Ulcerative colitis

___ Liver disease ___ HIV/AIDS ___ Osteoporosis ___Rheumatoid Arthritis

__ Kidney Disease __ Cardiovascular disease **If other(s), please specify:** __________________

13. **Have you had any of the following symptoms recently?**

__ Dry skin or hair __ Sleeping Disorder __ Fatigue __ Concentration or Memory Loss

__ Anxiety/Nervousness __Irritability __ Depression __ Muscle Weakness/Loss

__ Loss of Libido/Orgasm __Erectile/Vaginal Dysfunction __ Joint Pain

14. Have you had any surgeries and/or hospitalizations the doctor should be aware of?

___ Yes ___ No

If yes, please give the approximate dates: __________

15. 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 per day? ________ Since when? __________

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, describe what you do: _____________________________

How many hours do you typically sleep in a night?
___ Less than 4 hours ____ 3-4 hours ___ 5-8 hours ___ 8+ hours

16. Current emotional stress scale:
0- No stress/10- Extremely stressed

___ 0 ___ 1 ___ 2 ___ 3 ___4 ___5 ___6 ___ 7 ___ 8 ___ 9 ___10