Patient Intake Form

Date:

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Patient	Last Name	First Name	Middle Name
	Street Address		Birth Date
	City, State, Zip		Email Address
	Home Phone	Work Phone	Cell Phone
	SSN	Driver's License	Spouse's Name
Insurance	Name		Phone
	Address (street, City, State, Zip)		ID #
Employer	Name		Phone
	Address (street, City, State, Zip)		Occupation
Emergency Contact	Name		Phone
	Address (street, City, State, Zip)		Relationship
Referred by			

Main complaints
Symptoms
Western diagnosis
Medications taken in recent months
Allergies (you or close relatives)
Bleeding disorders, heart diseases, or epilepsy (you or any close relatives)
Recurring discomforts (headache, backache, digestion, elimination, sleep, menstruation)
Surgeries or major illnesses
Treatments in recent months
Past or present usage levels of drugs, alcohol, cigarettes, caffeine products
Additional information