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New Patient Intake Form

Patient Name: _____ **DOB:** ____ / ____ / ____

Nickname, Chosen name, etc.: _____ **SSN:** _____-____-_____ (For insurance verification)

Sex: ☐ Male ☐ Female **Pronouns:** ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Address:_____ **City:**_____ **State**:_____ **Zip**:_____

Email address:_____
Phone Number: *Appointment reminders will be sent to 1st number listed.*
□ Cell □ Home □ Work: (_____)_____Texts/Confidential Message OK? □Yes □No
□ Cell □ Home □ Work: (_____)_____Texts/Confidential Message OK? □Yes □No

Ethnic Group (Select One):	**Race: (Select all that apply)**	
□ Latino/Latina/Hispanic	□American Indian	□ Native Hawaiian
□Non-Hispanic or Latino/a	□ Alaskan Native	□ Pacific Islander
□ Declined/Unknown	□ Asian	□Other/Unknown/Declined
□ White	□Black/African American	

Marital Status: ☐ **Single** ☐ **Married** ☐**Significant other** ☐ **Widowed**
Employment Status (Check one): □ Full Time □ Part Time □ Retired □ Self-Employed
Occupation:_____
Employer:_____
Primary Language:_____
Primary Care Provider (PCP):_____
Referral Source: □PCP □Yelp □Apple Wellness Center □Prior patient □Google
□Other:_____

Family History:

Do you have a family history of any of the following?
Key: M-mother F-father, Si-sister, B-brother, D-daughter, So- Son

Diabetes:	□M □F □Si □B □D □So	High Blood Pressure:	□M □F □Si □B □D □So
Heart attack:	□M □F □Si B □D □So	Stroke:	□M □F □Si □B □D □So
High Cholesterol:	□M □F □Si □B □D □So	Cancer, type? _____	□M □F □Si □B □D □So

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Medical Conditions:

□High Blood Pressure □Gout
□Scoliosis □Arthritis
□Asthma □Foot ulcers
□High Cholesterol □Diabetes Mellitus
□Kidney Disease □Heart Disease
□Thyroid Disease □Foot Fracture or Surgery
□Osteoporosis □Numbness in feet/legs
□Peripheral Vascular Disease (PVD)
□Cancer, Type:_____

Surgeries/Hospitalizations:

□Appendectomy □C-Section
□Ankle Surgery □Foot Surgery
□Hysterectomy □Valve Replacement
□Tonsillectomy □Heart Surgery
□Orthopedic Surgery
□Other:_____

Tobacco Use: □Never Smoker □Former Smoker □Current Smoker
Packs/Day:_____ Years:_____

Do you drink alcohol? □Yes □No If Yes, how many per week? Drinks/Week:_____

Allergies:

(Please select all that apply)

□Sulfa □Penicillin □Aspirin □Codeine □Latex □ Adhesive tape □Medication:_____

Medications:

List all medications, vitamins, or other supplements you are taking.

Name of Medication	Strength/Frequency

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In the last few months has there been any recent changes in your:

□Weight □Work □ Activity □Shoe Gear □Flooring at work or home

Please explain:_____
_____

Please tell us what your Goals and Expectations are relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your visit today?**
_____
_____
_____
_____
_____
_____

Relating to your specific complaint(s), what would you like to be able to accomplish in the near future that you may not be able to do right at this moment? **(please include intermediate and long term goals)**_____
_____
_____
_____
_____
_____

OFFICE POLICIES

I acknowledge I was provided a copy of the **HIPAA Privacy Policy** and I have read and understand the notice. I acknowledge I was provided a copy of the **Office Financial Policy** and I have read and understand the notice. I agree to abide by all these policies.

_____

Signature of patient Relationship Date
(or financially responsible party)
*The typed name is acceptable as an electronic signature