Medical History and Intake Form 2019

Date:_____

Name:_____Date of Birth_____
Referring Provider:_____Reason for Referral:_____
Primary Care Provider:_____
Name and relationship of person completing this from (if person is not patient) _____
Email _____
Owner of insurance plan _____ Date of Birth _____ Social Sec No _____

symptoms:

Fatigue	Eye pain	Bowel accidents	Need for cane/ walker/ wheelchair	Trouble with walking
Fever	Chest pain	Bladder accidents		Falling
Weight loss	Palpitations	Urgency of urine	Headache/Migraine	Other symptoms:
Weight gain	Fainting	Pregnancy	Memory loss	_____
Accidents	Heart Problems	Impotence	Numbness	_____
Smoking	Shortness of breath	Depression	Tingling	_____
Vision changes	Trouble with sleep	Anxiety	Tremor	_____
Double vision	Snoring	Hallucinations	Seizure	_____
Vision loss	Morning fatigue	Anemia	Weakness	_____

Past Medical Problems

Alzheimers	Dementia	Heart Disease	Operations_____	Other_____
Parkinsons	Migraine	High Blood Pressure	_____	_____
Multiple Sclerosis	Head injuries_____	Anemia	_____	_____
Epilepsy	Neck injuries_____	Osteoporosis	_____	_____
Neuropathy	Tremor	Sleep Apnea	_____	_____
Stroke/TIA	Cancer_____	Fibromyalgia		_____
Toticollis	Thyroid	Asthma		_____
Spasticity	Diabetes			

Social History:

Job:_____ Exercise:_____ Recreational Drugs Y N
Education:_____ Tobacco Y N Cannibus Y N how often_____
Marital Status:_____ date quit _____date started_____ packs per day _____ecig _____
Number of Children:_____ Alcohol Y N

Family Health: List known medical conditions for family members:

Mother:_____
Father:_____
Siblings:_____
Grandparents:_____
Other:_____

Drug Allergies:

_____

Current Medications and Supplements taken:

_____
_____
_____
_____
_____