Initial Patient Intake Form

Patient Registration

Today's Date _______________

Patient Name ____
(last) (first) (middle)

Address ____
(city) (state) (zip)

Date of birth ____________________________(mm/dd/yyyy) SSN # ________________________________

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender

Home phone _________________ Cell phone ____________________ Email _____________________________

Employer ____ Work Phone _______________

Business Address ____
(city) (state) (zip)

Spouse's name ______________________________ Employer _________________________ Work Phone _________________

Name of Primary Care Provider (PCP) ____ Tel _____________________

Address ____ Fax _____________________

Referring physician (if not PCP) ____ Tel ___________________

Address ____ Fax _____________________

Emergency Contact Information

Name of friend/or nearest relative not living with you ____________________________________ Phone __________________

Address ____ Relationship to you: ____________________

Insurance Information

Name of insured ____ Relationship to patient: ______________________

Address ____ Contact phone ___________________________

Name of employer ____ Work phone ____________________

Primary Insurance Company _______________________________________ ID# _______________ Group # _______________

Address ____ city _____________ state __________ zip _____________

Secondary Insurance Company _____________________________________ ID# _______________ Group # _______________

Address ____ city __________ state _______ zip ___________

Social History:

Married _ Single Divorced (Year _____ _) Widowed (Year _____ _)

Present marriage/number of years __________ Previous marriage/number of years ______________

**If not previously indicated please complete*

*Present occupation ______________________ *Previous Occupations _________________________

*Education __________________________ *Spouse's Occupation ______________________________

Persons currently living in your home ____

Do you have a living will/Advanced Directive/Polst? No Yes (please provide a copy)

Language Spoken:

Primary Language: ________________ Preferred Language of Communication (if different): _________________

Needs Interpreter: Yes No (comfortable communicating with English)

Religion/Culture:

What is your religious affiliation (optional)? ____

Are there religious/cultural beliefs that will/could impact your treatment? No Yes

Please explain: ____

Self-Reporting History & Physical:

Reason for this visit (chief complaint) : ____ __

____ __

Onset of illness: ______________ Date: ____________ Symptom: ____________________________ ________

Do you have any know genetic/predisposition to disease? No Yes , explain: __________________________

____

Medical History:

Illness/injury Date

____

____

____

____

Surgeries/hospitalizations Date

____

____

____

____

*If more space needed please attach list to this page

Implants: No _ Yes , explain ____

Have you ever received Hormone Therapy or Chemotherapy? No Yes

Medical Oncologist: Name ________________________

Address ____

Medication: _____________________________________ Date Received: _______________

Medication: _____________________________________ Date Received: _______________

Have your ever received Radiation Therapy? No Yes

Radiation Oncologist: Name ________________________

Address ____

What area received radiation therapy? ____

Female:

Are you now, or is there a possibility that you might be pregnant? No Yes **Initials:** ________ Date:________

Number of pregnancies: ________ Deliveries: __________________ Did you Breastfeed? _______________

Have you ever taken Hormones?(Estrogens, Birth Control pills, Androgens, etc.) Yes No

If yes, what type and for how long? ____

Do you still have menstrual periods? No Yes Date of last period ______________

Habits:

Smoking? No ____ Yes ____ How many packs each day? ___________ For how many years? __________

Alcohol? No ____ Yes ____ What type? ______________________ How many drinks per week? _________

Have you ever used 'street' (illegal) intravenous drugs? No ____ Yes ____

Have you ever been tested for the HIV/AIDS virus? No ____ Yes ____ If yes, what was the result? ________

Have you ever been tested for Hepatitis? No ____ Yes ____ If yes, what was the result? ____________

A MIND AFFAIR

Allergies: (Medications, food, dust pollen, etc.) ____

Latex Allergy:

When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing, or rash? No _ Yes _, explain: ______________________________

Do you have spina bifida or repeated catheterizations from congenital defects? No _ Yes ,

explain: ____

Do you have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)? No _ Yes , explain ____

Current Medications (include non-prescription):

Name of Medication	Strength of Dose (mg)	How Taken	How Often	Time of Last Dose	Reason for Use

*If more space needed please attach list of medication to this page

A MIND AFFAIR

Review of Systems:

General	YES
Weight loss	☐
Loss of appetite	☐
Dry mouth/dehydration	☐
Fatigue	☐
Chills	☐

Skin:	YES
Redness/rash	☐
Swelling	☐
Moles	☐
Bruising	☐
Hair Loss	☐
Nail changes	☐

Eyes	YES
Vision changes	☐
Cataracts	☐
Redness	☐
Swelling	☐
Pain	☐

Ears	YES
Discharge	☐
Hearing Loss	☐

Nose	YES
Discharge	☐
Bleeding	☐

Throat	YES
Swelling	☐
Pain	☐
Mouth sores	☐

Immunologic	YES
Swollen glands	☐
Infections	☐
Fevers	☐
Autoimmune disease(lupus, rheumatoid arthritis)	☐

Breast	YES
Lumps	☐
Discharge	☐
Bleeding	☐
Pain	☐

Lungs	YES
Cough	☐
Blood in sputum	☐
Shortness of breath	☐
Asthma	☐
Tuberculosis	☐

Heart	YES
Chest pain	☐
Heart palpitation	☐
High blood pressure	☐

Gastrointestinal	YES
Nausea	☐
Vomiting	☐
Diarrhea	☐
Constipation	☐
Abdominal/stomach pain	☐
Black/bloody stool	☐

Urinary	YES
Kidney problems	☐
Bladder problems	☐
Blood in urine	☐
Burning urination	☐
Frequent urination	☐

Genital	YES
Prostate problems	☐
Scrotal pain	☐
Scrotal mass	☐
Ovary problems	☐
Uterus problems	☐
Vaginal discharge	☐
Vaginal Pain	☐

Hormonal	YES
Diabetes	☐
Thyroid problems	☐
High cholesterol	☐

Blood	YES
Anemia	☐
Low blood counts	☐
Blood clots	☐

Neurologic	YES
Numbness	☐
Tingling	☐
Dizziness/fainting spells Headaches	☐
Seizures	☐
Multiple sclerosis	☐

Psychiatric	YES
Depression	☐
Anxiety	☐
Schizophrenia	☐
Mania	☐

Family History:

Relation	Age	State of Health	Cancer Diagnosis	Deceased, cause of Death	Age of Death	Known Genetic Abnormality
Father						
Mother						
Siblings						
Children						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Other Relatives						

PLEASE LIST ALL OF YOUR PRESENT PHYSICIAN:

	Referring Physician ☐ Seen for current problem	Other Physician ☐ Seen for current problem	Other Physician ☐ Seen for current problem
Name			
Address			
Telephone			
	☐ Please send reports to this physician ☐ Do Not send reports	☐ Please send reports to this physician ☐ Do Not send reports	☐ Please send reports to this physician ☐ Do Not send reports

Should We Contact Someone to Obtain Your Records?

	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility
Name			
Address			
Telephone			
Study (CT, MRI, Biopsy, etc)			

Patient Signature: ___________________________________ **Date:** _____________________________

If completed by someone other than patient:

Name: ____ **Relationship:** ______________________