



### PATIENT INTAKE FORM

Name:	_____
MR #:	_____
DOB:	_____
or Apply Patient Label	

#### Medical Information

Patient's Name \_\_\_\_\_ Date of Last visit \_\_\_\_\_  
 Sex:  M  F Age \_\_\_\_\_ Yrs \_\_\_\_\_ months

Reason for today's visit? \_\_\_\_\_

When did the problem first start? \_\_\_\_\_

Since you first noticed it, is the problem:  Better?  
 Worse?  
 The same?

Please Explain all YES answers \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there any pain?  No  Yes Location: \_\_\_\_\_

Has this problem been treated previously \_\_\_\_\_ How? \_\_\_\_\_

Is there a family history of this or a similar problem?  No  Yes In whom? \_\_\_\_\_

#### Past Medical History

Any major illnesses?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Previous operations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Current Medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Allergies to medications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

#### Patient's Birth History

For mother: # of pregnancies \_\_\_\_\_ # of children \_\_\_\_\_ # of this child \_\_\_\_\_

Birth place (Hospital) \_\_\_\_\_ (City) \_\_\_\_\_

Birth weight \_\_\_\_\_ Lbs \_\_\_\_\_ oz

Premature  No  Yes # weeks gestation \_\_\_\_\_

Problems?  No  Yes \_\_\_\_\_

Breech position  No  Yes \_\_\_\_\_

Caesarian section  No  Yes If yes, give reasons \_\_\_\_\_

#### Developmental History

Child sat up at \_\_\_\_\_ (age)

Child walked at \_\_\_\_\_ (age)

Child spoke at \_\_\_\_\_ (age)

#### Review of systems (Any problems with the following)

Heart system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lung system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Neurologic system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Urologic system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gastrointestinal system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Immune system	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Signature of person completing this form \_\_\_\_\_

Relationship to patient \_\_\_\_\_

