Premier Healthcare Patient Intake Form

Date:___/____/______

____

(Legal) First Name (Legal) MI (Legal) Last Name DOB Age

Street_______________________________ Apt _______ City______________________ State_________ Zip__________

SS#:_______________________________ MARITAL STATUS :[ ] S [ ] M [ ] W [ ] D Spouse ____________________

DL#:____

Language: __English__Spanish__Indian__Japanese__Chinese__Korean__French__German__Russian Other_________

Race/Ethnicity: _____White_____American Indian or Alaska Native_____Asian_____Native Hawaiian/Other Pacific Islander _____Black or African American_____Hispanic or Latino_____Decline to Answer

Contact Info: Home Ph: __________________ Work Ph: ______________________ Cell Ph: _______________

Hm/E-Mail:______________________ Wk/E-Mail:______________________ Cell Carrier:_______________

Contact Preference: [__Ph/Home][__Ph/Work][__Ph/Cell] [__Ph/Text] [__Hm/E-Mail][__Wk/E-Mail][__Postal Mail]

Emergency contact: ______________________________________ Phone: ______________________

Who Referred you to our office? ____________________________ Phone: ______________________

Occupation: ___________________________ Employer:_______________________________________

Employer's Address: ____

Street City State Zip

INSURANCE INFORMATION: (Please supply copy of Insurance Card and one form of picture ID)

Are you the policy holder? [__]Y or [__]N If no, who is? [__]Spouse [__]Parent [__]Employer [__]Other:__________

____

Policy Holder's First Name MI Last Name DOB:

Policy Holder's SS#:_______________________

Policy Holder's Employer:____

Do you have secondary insurance? [__]Y or [__]N If yes, please complete the following:

____

Policy Holder's First Name MI Last Name DOB:

Policy Holder's SS#:_______________________

Policy Holder's Employer:____

PAST PATIENT HISTORY:

Have you *ever* been involved in:

(Please indicate date(s) of injury, is case open or closed, is there a future award. For open awards please give claim #(s)

Work related injury? [__]Y or [__]N If yes, please explain:__/__/______________________________________

____

____

Auto/Personal injury? [__]Y or [__]N If yes, please explain:__/__/______________________________________

____

____

MEDICAL HISTORY:

□AIDS/HIV □AIDS/HIV □Alcoholism □Appendicitis □Arteriosclerosis □Asthma □Cancer

□Chicken Pox □Diabetes □Emphysema □Epilepsy □Fibromyalgia □Goiter □Gout

□Heart Disease □Hepatitis ____ □Herpes □High Blood Pressure □Measles □Multiples Sclerosis

□Mumps □Pacemaker □Pleurisy □Pneumonia □Polio □Rheumatic Fever □Rheumatoid Arthritis

□Scarlet Fever □Seizures □Shortness of Breath □Stress □Stroke □Trauma At Birth □Tuberculosis

□Typhoid Fever □Ulcers □Whooping Cough □Venereal Disease (type)__________________________

☐Surgery(type & date)____
☐Other (include date)____
☐Allergies (type)____

For Women Only:

Date Of Last Period_____/_____/_____ ☐Cramping ☐Irregularity

Are You Pregnant: [__]Y or [__]N If yes, due date:____/____/____

Of Vaginal Births___________ # C-Section Births_____________

PRESENT SYMPTOMS / CHIEF COMPLAINTS: (please circle areas affected and check appropriate box)

[HEAD]	[NECK]	[MID BACK]	[LOW BACK]	[CHEST]
☐headache	☐neck pain	☐mid back pain	☐low back pain	☐pain
☐loss of memory	☐tightness	☐tightness	☐tightness	☐rib pain
☐light headedness	☐tenderness	☐tenderness	☐tenderness	
☐dizziness	☐numbness	☐numbness	☐numbness	
	☐muscle spasm	☐muscle spasm	☐muscle spasm	

[GENERAL]

☐constipation ☐depressed ☐fatigue ☐irritable ☐loss of sleep
☐loss of weight ☐nervousness ☐ringing in the ears ☐shortness of breath

[SHOULDER / ARM]	[ELBOW / FOREARM]	[WRIST / HAND / FINGERS]	[HIP / UPPER LEG]	[KNEE / LOWER LEG]
☐left ☐right	☐left ☐right	☐left ☐right	☐left ☐right	☐left ☐right
☐pain	☐pain	☐pain	☐pain	☐pain
☐tightness	☐tightness	☐tightness	☐tightness	☐tightness
☐tenderness	☐tenderness	☐tenderness	☐tenderness	☐tenderness
☐numbness	☐numbness	☐numbness	☐numbness	☐numbness
☐muscle spasm	☐muscle spasm	☐muscle spasm	☐muscle spasm	☐muscle spasm

Do You Have Any Radiating Pain? [ ]Y or [ ]N If yes, please explain:____

____

When Did Your Symptoms Begin?__/__/_____

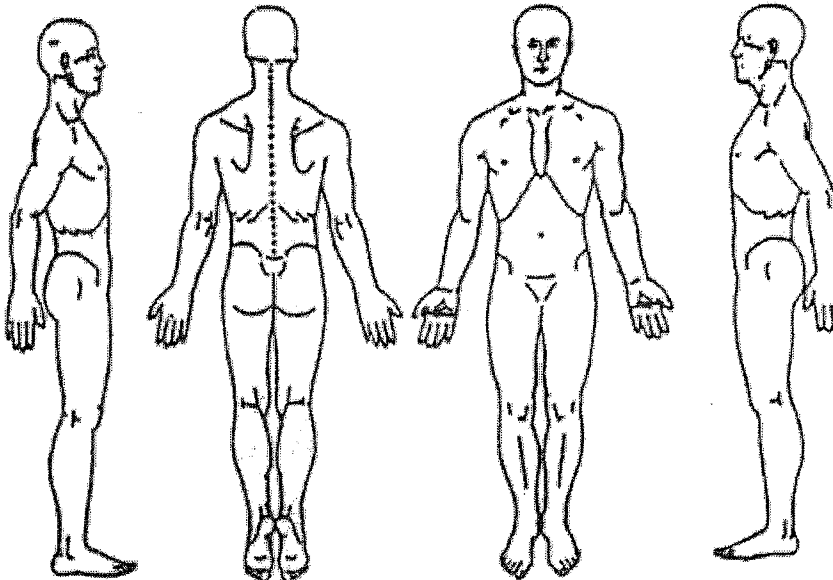
What Were You Doing When Your Pain Increased?____

On the pain scale, please rate your or discomfort: (0 being no pain, 10 being excruciating/unbearable)

1	2	3	4	5	6	7	8	9	10

Please mark the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

A=Aching *B*=Burning *C*=Cramping *D*=Dull *N*=Numbness *S*=Stabbing *T*=Tingling(pins and needles)



Signature: Date: