MEDICAL INTAKE FORM

Options Location: Options Counseling and Family Services Location: ▼

Client Name: **Age:** **Height:** **Weight:**
Date of Birth:

Which hand do you use to write? ○Left○Right

PCP:

Are your immunizations up-to-date? ○No○Yes

Do you exercise? ○No○Yes

If yes, please describe:

Tobacco: ○No○Yes

If yes, # of cigarettes/day: # of years: Last use?

Alcohol: ○No○Yes
If yes, frequency? Last use?

Marijuana: ○No○Yes

If yes, frequency? Last use?

Drug use: ○No○Yes

If yes, frequency? Last use?

Are you pregnant? ○No○Yes

Is it possible you could be pregnant? ○No○Yes

MEDICAL HISTORY - Please check *current* or *previous* medical conditions.
☐ Anemia☐ Asthma☐ Blood clots☐ Thyroid ☐ Anxiety☐ Diabetes ☐ Frequent UTI☐ Fibromyalgia☐ Heart attack☐ Emboli ☐ Alcoholism☐ Depression ☐ Emphysema☐ Liver Disease☐ Arthritis☐ HIV☐ Heart disease☐ Cancer☐ MRSA infection ☐ Osteoporosis☐ Kidney Disease☐ Gout☐ Neuropathy ☐ High cholesterol☐ Rheumatoid arthritis☐ RSD/CRPS ☐ High blood pressure☐ Sexual Dysfunction☐ Stroke/Seizure☐ Substance abuse☐ Psychiatric illness☐ Ulcers/Wounds☐ Irregular heartbeat☐ Sleep Apnea

Head injury with loss of consciousness? ○Yes○No

If yes, when? _____
Head injury without loss of consciousness? ○Yes○No
If yes, when? _____
☐ Other
_____

PAST SURGICAL HISTORY - Please list any previous surgical procedures, the date, and location.

Procedure:	Date:	Location

FAMILY HISTORY – Please check medical conditions that are present in your family history.
Cardiac: ☐ Heart attack☐ Irregular heartbeat☐ Sudden death

Musculoskeletal: ☐ Arthritis☐ Rheumatoid disease
Neurological/Psychiatric: ☐ Seizures☐ Stroke☐ Depression☐ Psychosis
Endocrine/Hematologic: ☐ Thyroid☐ Diabetes☐ Bleeding/clots
Anesthesia problems: ☐ No☐ Yes
Cancer: ☐ No☐ Yes
Musculoskeletal: ☐ Arthritis☐ Rheumatoid disease

REVIEW OF SYSTEMS – Please check if you have *current symptoms or* medical problems in the following areas.
Constitutional ☐ None☐ Weight loss ☐ Weight gain ☐ Insomnia☐ Chronic Fatigue ☐ Other

Other _____

Ears, Nose, Throat ☐ *None* ☐ *Loss of Hearing* ☐ *Seasonal Allergies* ☐ *Sinus Pain* ☐ *Ringing in Ears* ☐ *Other:*

Other:

Heart ☐ *None* ☐ *Chest Pain* ☐ *Hypertension* ☐ *Edema* ☐ *Palpitations* ☐ *High Cholesterol* ☐ *Other:*

Other

Respiratory ☐ None ☐ Asthma ☐ Wheezing ☐ Frequent Cough ☐ Other:

Other

GI ☐ None ☐ Heartburn/Indigestion ☐ Ulcer ☐ Abdominal Pain ☐ Stomach Bleed ☐ Other

Other

Skeletal ☐ None ☐ Arthritis ☐ Muscle Weakness ☐ Joint Pain ☐ Back Pain ☐ Other:

Other

Skin ☐ None ☐ Rash ☐ Ulcers ☐ Scars ☐ Other :

Other

Neurological ☐ None ☐ Headaches ☐ Seizures ☐ Numbness ☐ Dizziness ☐ Other:

Other

Psychiatric☐ None ☐ Depression ☐ Mood Swings ☐ Anxiety ☐ Other:

Other

Endocrine ☐ None ☐ Diabetes ☐ Hypothyroid ☐ Hyperthyroid ☐ Hot Flashes ☐ Other

Other

Hematology ☐ None ☐ Easy Bruising ☐ Bleeding ☐ Anemia ☐ Other:

Other

Pain *Do you have pain?* ☐ *No*☐ *Yes*

If yes, pain location: Location

Pain Intensity - Please elect the number, or range of numbers, that best describes the intensity of your pain.
☐ 0.....☐ 1.....☐ 2.....☐ 3.....☐ 4.....☐ 5.....☐ 6.....☐ 7.....☐ 8.....☐ 9.....☐ 10.....

Mild Moderate Severe Worst pain imaginable

ALLERGIES ☐ None☐ Penicillin☐ Sulfa☐ Latex☐ Other:

Other

MEDICATIONS - Please list the medications you are taking below.

Medication:	Prescriber:	Frequency:	Dose: Start Date

X

Signature Certificate

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