1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

Initial Intake Form

Name: ____
Last First MI

Mailing Address: ____

City: ______________________ State: ______________ Zip: ______________

Email address: ____

Phone # (H)______________ (W) ______________ (Other) ______________

Can we call you at work? ❑ Yes ❑ No
Can we leave a voicemail? ❑ Yes ❑ No

Date of Birth: ______________ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: ______________________ Employer: ______________________

How did you hear about our practice? ______________________

Emergency contact: Name: ______________________Relation: ______________

Phone #: (H) ______________ (W) ______________

Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ______________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ______________

Policy Holder Name: ______________________ D.O.B. :______________

Relationship to patient (if other than self): ______________ Phone # ______________

Family Physician and Other Providers

Name: ______________ ______________Phone # ______________

Name: ______________ ______________Phone # ______________

Name: ______________ ______________Phone # ______________

Name: ______________ ______________Phone # ______________

1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

Health History

PRESENTING PROBLEM AND CURRENT TREATMENT PLAN:

____

____

____

SECONDARY HEALTH ISSUES

____

____

____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Anemia	❑ Arthritis	❑ Blood Disease	❑ Cancer
❑ Cataracts	❑ Colds(frequent)	❑ Diabetes	❑ Digestive Problems	❑ Eczema
❑ Epilepsy	❑ Headaches	❑ Hepatitis	❑ Herniated Disc	❑ Herpes
❑ Hypertension	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease	❑ Lyme
❑ Miscarriage	❑ Pneumonia	❑ Prostate Problems	❑ Rheumatoid Arthritis	❑ Stroke
❑ Tumors/Growth	❑ Tuberculosis	❑ Ulcers	❑ Urinary Tract Infections	❑ Venereal Disease

Please list any medications you are currently taking (**Be sure to include dosage/frequency**)____________________________

____

____

____

____

____

____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

____

____

____

____

1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

Please list any surgeries and/or hospitalizations you have had (**type & date**): ____

____

____

Please list any allergies (medication/food/insects,ect): ____

____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Women's Health: Last menstrual cycle:_____________________

Number of Pregnancies:______________ Number of Children: _______________ Number of Miscarriages: ____________________

Any sexual difficulties?____

Men's Health: Last Prostate Exam: ____________________

Any sexual difficulties? ____

Please continue to next page

1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

Review of Systems

Please mark if you have experienced any of these symptoms within the last 6 months:

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Print Name: ______________________________________

SIGNATURE (X) ________________________________ **DATE** ____________________

By typing your name on the above line, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. Information given by you in this document is true and correct to the best of your knowledge. You understand and agree that you didn't provide any false information, misrepresentation, or omission of facts in the above document.