REVITALIZE MEDICAL CENTER

Welcome to our Practice!

How did you hear about us? Please check all that apply.

☐ Referral from _____

PATIENT DEMOGRAPHIC INFORMATION			
Name			Date of Birth
Last 4 of Social Security Number	Sex	Weight Height	Marital Status □ Single □ Married □ Partner □ Divorced □ Widow
Referring Physician Name, Phone #		Primary Care Physician Name, Phone #	
Employment Status □Employed □Unemployed □Student □Retired □Military □Disability			Employer/School Name
PRESCRIPTION PLAN			
Name, Phone #		ID#	Group #
PREFERRED PHARMACY NAME/ADDRESS:			

IS THIS A WORKMAN'S COMPENSATION OR MOTOR VEHICLE CLAIM?			□Yes □No
Date of Accident	Adjustor Name	Company Name/Phone #	Claim #

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NEW PATIENT INTAKE FORM

MEDICAL HISTORY:

Have you ever been diagnosed with the following (please circle):

Cancer	**Kidney Problems**	**Stroke/TIA**	**Autoimmune Disease**
Asthma	**High blood pressure**	**Anxiety/Depression**	**Rheumatoid Arthritis**
COPD	**Diabetes**	**Thyroid Disease**	**Osteoarthritis**
CHF/Heart Attack	**Bleeding Disorder**	**Stomach/Bowel issues**	**Reflux**

FAMILY HISTORY:

Anyone in your immediate family been diagnosed with the above conditions? Please list which ones.

GENERAL HISTORY:

Are you allergic to anything (medication, food, or latex?) ☐ **Yes*** ☐ **No** ***If yes, describe:**

Are you allergic to Iodine or Shellfish? ☐ **Yes*** ☐ **No** ***If yes, describe reaction:**

Please list any blood thinners you take: (aspirin, heparin, Coumadin etc.)

PREVIOUS SURGERIES/HOSPITALIZATIONS/INJURIES

(List all with approximate dates)

	Date
	/ /
	/ /

SUBSTANCE USE

(Which of the following drugs or substances do you use currently or have used in the past?)

Alcohol How much?	Current ❒ Yes ❒ No Per Week ___	Past ❒ Yes ❒ No Per Week ____	**Heroin/Cocaine/ Amphetamines (please circle)**	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No
Marijuana	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No	**Other drugs:_____ _**	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No
Cigarettes	Current ❒ Yes ❒ No	Past ❒ Yes ❒ No	If "yes" to either, how many packs do you/did you smoke per day? _____ If you quit, how long has it been? _____		

DOMESTIC SITUATION

With whom do you live?	Name:	Relationship:
Are you currently working? Part-time vs full time?	*❒ Yes ❒ No	*If Yes, occupation:
Are you able to care for yourself?	❒ Yes *❒ No	*If No, enter name of caregiver: _____

Please list all herbal supplements/vitamins including doses and frequency.

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Please list all prescription and over the counter medications, including doses and frequency.

PAIN HISTORY

When and how did your pain start? (i.e., suddenly, gradually, or injury)

Has it gotten better or worse since it started?	Approximate Date Pain Began / /

What treatments have you tried in the past for your pain?	Which position is worse? (Mark all that apply) ❒ Sitting ❒ Standing ❒ Walking

Please circle if you have any of the following and list the date of exam:

X-Ray	**CT Scan**
MRI	**EMG/Nerve Test**

Circle all of the words that describe your pain:

Sharp	Aching	Intermittent	Nagging	Throbbing	Tender
Shooting	Numb	Burning	Tingling	Stabbing	Continuous

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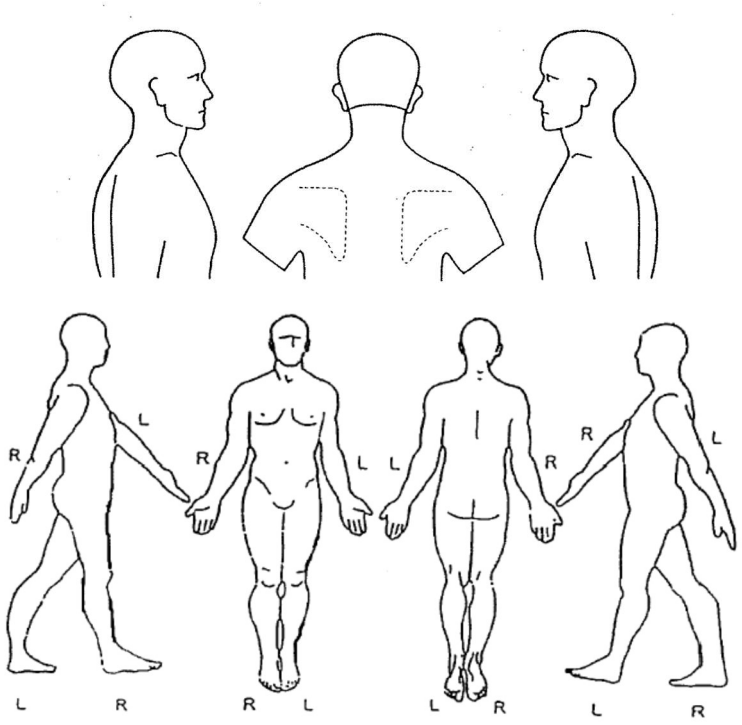
Please rate your pain **during the last month** by circling the number that best describes your pain at its:

Worst	0	1	2	3	4	5	6	7	8	9	10
Least	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10

Please mark below the location of your pain



Please circle Yes or No if you are currently experiencing the following:

Fever	YES/NO	Blood in urine	YES/NO
Fatigue	YES/NO	Numbness/tingling	YES/NO
Blurry Vision	YES/NO	Weakness	YES/NO
Eye Pain	YES/NO	Muscle pain	YES/NO
Trouble Hearing	YES/NO	Headaches	YES/NO
Irregular heartbeat	YES/NO	Seizures	YES/NO
Fainting	YES/NO	Difficulty sleeping	YES/NO
Loss of Balance	YES/NO	Anxiety	YES/NO
Trouble breathing	YES/NO	Depression	YES/NO
Cough	YES/NO	Suicidal thoughts	YES/NO
Heartburn	YES/NO	Bleeding	YES/NO
Diarrhea	YES/NO	Anemia	YES/NO
Nausea/vomiting	YES/NO	Pain with urination	YES/NO

What physical activities do you participate in & how often?

_____

Hobbies/interests:

_____

Describe your sleep: include # hours/night

_____

What are the major stressors in your life?

_____

_____

What types of complementary & alternative medicine have you tried in the past?

_____

_____

Nutrition History

How many servings of fruit/vegetables do you usually eat/drink each day?

_____

How much red meat do you eat per week?

_____

How much fish/seafood do you eat per week?

_____