Established Patient Intake Form

Patient Sticker

**General Information, Reason for your visit**

**Since your last visit have you:**

<table>
<thead>
<tr>
<th>Pain</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced any pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Medical History</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had any changes in family medical problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review of Systems (Subjective)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you experienced these symptoms in the last 6 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### General Symptoms

- Fatigue
- Fever / Chills
- ENT
- Cold Sores
- Ear Problems
- Nosebleeds

**Respiratory**

- Cough
- Shortness of Breath
- Wheezing

**Cardiovascular**

- Chest Pain
- Leg Pain with walking
- Palpitations

**Gastrointestinal**

- Nausea / Vomiting
- Trouble Swallowing
- Bloating
- Abdominal distention
- Fecal incontinence
- Bowel urgency
- Feeling full easily
- Excess gas

**Genitourinary**

- Blood in Urine
- Trouble Urinating

**Skin**

- Acne
- Dermatitis
- Dry Skin
- Itching / Rash
- Keloids
- Skin Ulcers

**Neurological**

- Confusion
- Headaches
- Tremors

**Psychiatric**

- Feel Anxious / Depressed
- Insomnia

**Endocrine**

- Weight Gain / Loss

### Procedure History:

<table>
<thead>
<tr>
<th>Had any procedures or surgeries since your last visit</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Social History

- Smoked
- Drink alcohol
- Taken illegal drugs

### Medications

**Since your last visit are there changes to the medications you are taking**

**Please list any changes**

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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