

PATIENT INTAKE SHEET

Date of Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Chart #: \_\_\_\_\_

Athena ID#: \_\_\_\_\_

Prescription Plan Name: \_\_\_\_\_  
(i.e. Insurance Company)

Insurance ID#: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Visit:  New  Follow-up  Second Opinion  ER Follow-up (Date in ER \_\_\_\_\_)

I understand that I am entering into a contractual relationship with medical practice/physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost of and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by medical practice/physician, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against medial practice/physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties certified expert medical witness(es) in the same or similar specialty as physician. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to make an opinion on such a case. In further consideration for this I, (the physician), agree to the same stipulations.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

Reason for being seen (List detailed symptoms, location and progress, and description of pain)

*Example: I am having pain in my right hip with radiation down to my knee, and weakness.*

\_\_\_\_\_

Approximate date of onset \_\_\_\_\_ Have you had surgery for this problem (What, Where, and When)?

\_\_\_\_\_

Have you had any of the following performed for this problem?

X-Ray  MRI  CT Scan  EMG  Other, please specify \_\_\_\_\_

Where and When? \_\_\_\_\_

Cortisone injections? Yes No # of injection \_\_\_\_\_ Dates \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medications (please list name and dosage)

For this problem: \_\_\_\_\_

\_\_\_\_\_

For other conditions or illness: \_\_\_\_\_

\_\_\_\_\_

Please list allergies to medications or state NONE (Name Reaction) \_\_\_\_\_

\_\_\_\_\_

CONTINUED NEXT PAGE

Date of Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Chart #: \_\_\_\_\_

Athena ID#: \_\_\_\_\_

**CONTINUED FROM PREVIOUS PAGE**

Have you had physical therapy for this problem?  Yes  No

Sports in which you participate \_\_\_\_\_  Daily  3-5 x Weekly  Occasionally

Occupation \_\_\_\_\_

Current Work Status:  Employed  Unemployed  On Disability

**Past Medical History--Have you been treated for any of the following problems?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart                     | <input type="checkbox"/> Lungs                   | <input type="checkbox"/> Liver            |
| <input type="checkbox"/> Kidney                    | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Blood Pressure (high/low) | <input type="checkbox"/> Diabetes (Insulin? Y/N) | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Psoriasis                 | <input type="checkbox"/> Cancer (Where? _____)   | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Infections              | <input type="checkbox"/> Anemia           |
| <input type="checkbox"/> Bleeding Disorder         | <input type="checkbox"/> Blood Clots             | <input type="checkbox"/> Psychiatric      |
| <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Depression/Anxiety      | <input type="checkbox"/> Sleep Apnea      |

List what surgery(s) you have had? (Approximate dates) \_\_\_\_\_  
\_\_\_\_\_

Complications from surgery or anesthesia? \_\_\_\_\_

Blood transfusions in the past?  Yes  No

**Social History:** Tobacco:  Yes How many years? \_\_\_\_\_  No  Quit (when?) \_\_\_\_\_  
 Cigarette  Pipe  Cigar  Chew

Alcohol use:  Heavy  Moderate  Social  
 Occasional  None

Substance Abuse:  Yes  No Type \_\_\_\_\_

**Family History--Problems in direct relatives:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Sickle Cell          | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Obesity              | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Psychiatric Problems |   |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver Disease        |   |

Referred for Opinion & Consult by \_\_\_\_\_

\_\_\_\_\_  
**PATIENT'S SIGNATURE**

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**