ANCHOR
RESTORATIVE MEDICINE

PATIENT INTAKE FORM

DATE: _____

Full Name: _____

Address: _____City/State/Zip _____

Cell _____ Home _____ Work_____

Email _____

* Email will not be shared and will only be used for occasional office announcement and appointment reminders

Preferred contact method: ☐ Phone ☐ Text ☐ Email

D/O/B: _____/ _____ / _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation _____Employer _____

Primary Language: ☐ English ☐ Spanish

Do you need an interpreter? ☐ Yes ☐ No

In case of an emergency, who can we contact?

Emergency Contact_____

Phone _____ Relationship to Patient _____

PHARMACY INFORMATION

Preferred Pharmacy: _____

Phone: _____ Location _____

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PATIENT MEDICAL HISTORY

Primary Care Physician _____

Address _____ Phone _____

Current Medical Condition:

Please describe _____

_____

_____

_____

Did the symptoms come on: ☐Suddenly ☐Gradually
Is the pain: ☐Mild ☐Moderate ☐Severe

Do your symptoms interfere with daily life? ☐Yes ☐No

Are your symptoms worse at certain times of the day? ☐ Yes ☐No

What do you hope to gain from this evaluation? _____

_____

Allergies: Please list any allergies you have to medications or food:

☐No Known Allergies ☐Adhesive Tape ☐Anesthesia ☐ Aspirin ☐Latex

☐Penicillin ☐Dairy Products ☐Other Medications _____

☐Other _____ ☐ Other_____

Social History Please check:

Do you drink alcohol? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Infrequently

Do you smoke? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Infrequently

Do you drink caffeine? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Infrequently

Family History: Please indicate if any of your immediate relatives have had any of the following by checking the appropriate box.

Condition	Father	Mother	Sibling(s)

Medical History: Have you had any of the following?

☐None	☐Celiac Disease	☐Hypertension
☐Allergies	☐Congestive Heart Failure	☐ Hypothyroidism
☐Anemia	☐Diabetes	☐Anxiety
☐Arthritis Conditions	☐Chronic Fatigue Syndrome	☐Infection Problems
☐Asthma	☐Drug/Alcohol Abuse	☐Kidney Problems
☐Atrial Fibrillation	☐Fibromyalgia	☐Menopause
☐Bleeding Problems	☐Migraine/ Headaches	☐Heart Disease

☐Neuropathy ☐Low Blood Sugar ☐Cancer

☐Chest Pain ☐Depression ☐Insomnia

☐Stroke ☐Cardiac Arrest ☐Seizure Disorders

☐Osteoporosis ☐Shortness of Breath ☐Tremors

☐Sinus Conditions ☐Gerd ☐Other

☐Auto Immune Disease ☐Pulmonary Embolism ☐Other

Medications: Please list any medications you are currently taking. Prescribed or over the counter

Medication	Dosage	Prescribing Doctor

Referral: How did hear about us?

☐Billboard ☐Radio ☐TV ☐Referral _____

☐Search Engine ☐Facebook ☐YouTube ☐Spotify ☐Other _____

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PAYMENT INFORMATION

Name of Party Responsible for payment _____

Do you have health insurance? ☐Yes ☐No Name of Insurance _____

AKNOWLEDGMENT

By signing this form, I confirm that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Date: _____

Practitioner's Name _____ Signature _____