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PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Address: _____

Home #: _____ Cell #: _____

Work #: _____ Email: _____

YES / NO Do you want messages to be left on your answering machine? If yes, please place a star by the phone number to be used for communication. If number is different from the above, please provide name/number.
Name: _____ Number:_____

Social Security #: _____ DOB: _____/_____/_____ Age: _____

Allergies:_____

Emergency Contact Person: _____

Relationship to you: _____ Contact #: _____

Pharmacy: _____ Pharmacy Phone#:_____

Primary Care Physician: _____ Telephone: _____

How did you hear about my office? _____

1. How often do you experience your symptoms?
   □ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
   □ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

2. How are your symptoms changing with time?
   □ Getting Worse □ Staying the Same □ Getting Better

3. Using a scale from 0-10 (10 being the worst), how would you rate your mood?
   0 1 2 3 4 5 6 7 8 9 10 (Please circle)

4. How much has the problem interfered with your work?
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

5. How much has the problem interfered with your social activities?
   □ Not at all □ A little bit □ Moderately □Quite a bit □ Extremely

6. Do you consider this problem to be severe?
   □ Yes □ Yes, at times □ No