AWAKEN WELLNESS NC

Patient Intake Form

Last Name: _____**First Name:**_____ **MI:**_____ **Date of Birth:** _____

Age: _____ **Male or Female:** _____ **Social Security #:**_____

Home Address: _____
Street *City* *State* *Zip*

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Employer: _____ **Primary Language Spoken:** _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Referring Doctor: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse Name: _____ **Date of Birth:** _____

Primary Insurance

Insurance Co: _____ **Policy #** _____**Group #**_____

Subscribers Name: _____**SS#**_____**DOB**_____

Address if Different than Patient: **Phone:** **Relationship to Patient:**

_____ _____ _____

Street *City* *State* *Zip*

Secondary Insurance

Insurance Co: _____ **Policy #** _____**Group #**_____

Subscribers Name: _____**SS#**_____**DOB**_____

Address if Different than Patient: **Phone:** **Relationship to Patient:**

_____ _____ _____

Street *City* *State* *Zip*

Emergency Contact (EC) / Release of Information (ROI)- Please Check the Boxes that Apply:

Name of Person to Contact in case of Emergency/ or we may release information to:

Name: _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ ROI **Name:** _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ROI **Name:** _____ **Phone:** _____**Relationship:** _____ ☐EC ☐ROI

Communication: ☐ Message may be left ☐ Answering Machine ☐ Family Member_____ **Living Will?** ☐N ☐Y **Durable Power of Attorney?** ☐N ☐Y (if yes) Name:_____

Phone: _____

Relationship: _____

*Print:*_____ *Signature:*_____ *Date:* _____

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Patient Initials:_____ DOB: _____ Height:_____ Weight: _____ lbs

Current Symptoms/ Reason for Visit : Length of time:

1.	
2.	
3.	

Are your Symptoms?

	Yes	No	When
Work Related?	___	___	_____
Injury Related?	___	___	_____
Did you stop working?	___	___	_____
Did you return?	___	___	_____

Recent Testing? (Last 6 Months) □No □Yes

Test Name	Date
1.	
2.	
3.	

Current Symptoms: Please Check All that Apply

□ Abdominal Pain
□ Back Pain
□ Blood in Urine
□ Bloody/ tarry stool
□ Bruise Easily
□ Change in bowel habits
□ Chest Pain
□ Cold numb feet
□ Constipation
□ Convulsions/ Seizures
□ Cough
□ Diarrhea
□ Difficulty Swallowing
□ Dizziness/ Fainting
□ Ear Infection
□ Failing Vision
□ Fatigue
□ Fever
□Foot Pain
□ Frequent Urination
□ Hair Loss
□ Headaches
□ Hemorrhoids
□ Hernia
□ Hives
□ Hoarseness
□ Indigestion/ Heartburn
□ Insomnia
□ Joint Pain
□ Leg Pain
□ Loss of Appetite
□ Lumps/ Masses
□ Memory Loss
□ Moodiness
□ Muscle Weakness
□ Nausea/ Vomiting
□ Nervousness
□ Night Sweats
□ Nosebleeds
□ Numbness/ Tingling
□ Pain/ Bleeding during Sex
□ Painful Urination
□ Phobias
□ Rashes
□ Ringing in Ears
□ Sexual Dysfunction
□ Shortness of Breath
□ Sinus Trouble
□ Sore Throat
□ Swollen Ankles
□ Tooth/ Gum Trouble
□ Tremors
□ Urethral Discharge
□ Varicose Veins
□ Weight Loss

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Patient Initials: _____ DOB: _____

Previous Surgery	Hospital	Date

Problems with Anesthesia in the past? □N □Y-Explain_____
Do you have a Pacemaker? □N □Y
Please list any serious injuries: _____

Family History	Illness	Deceased	Living
Father			
Mother			
Brother			
Sister			
Children			
Other			

Social History

Do you live alone? □Y □ N- who? _____
Number of Children- _____
Do you exercise regularly? □ Y □ N
Which is your Dominant Hand? □ Right □Left
Highest grade level completed? _____
Occupation? _____
Are you on a special diet? _____

Do you use any of the following- Please check all that apply

	Yes	Never	Quit	Amount per Day
Recreational Drugs				
Alcohol				
Tobacco				
Caffeine				

Please complete if applicable:
Are you planning a pregnancy? □ Y □ N
What kind of contraception are you using currently?
_____ Are you pregnant now? □ Y □ N
When was your last menstrual cycle? _____

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Patient Initials:_____ DOB:_____

Patient Medical History	Yes	No		Yes	No		Yes	No
AIDS			Eczema			Multiple Sclerosis		
Anemia			Emphysema			Mumps		
Anxiety			Epilepsy			Muscle Disorder		
Arrhythmia			Eye/ Ear Disorder			Neuropathy		
Arthritis			Genetic Defects			Osteoporosis		
Asthma			Gout			Parkinson's Disease		
Birth Defect: _____			Hayfever/ Allergies			Phlebitis		
Blood Disorder/ Clot			Heart Attack			Pneumonia		
Bone/ Joint Disorder			Heart Disease			Polio		
Bronchitis			Heart Murmur			Prostate Disease		
Cancer: Type _____			Hepatitis: Type _____			Psoriasis		
Chicken Pox			Herpes			Rubella		
Cirrhosis/ Liver			High Blood Pressure			Seizures		
Colitis			Jaundice			Skin Disease		
Congestive Heart Failure			Kidney Failure			Sleep Apnea		
COPD			Kidney Stones			Stroke		
Crohn's Disease			Lactose Intolerant			Tetanus		
Deep Vein Thrombosis			Low Blood Pressure			Thyroid Disease		
Depression			Lung Disease			Tuberculosis		
Diabetes			Measles			Ulcers		
Diptheria			Mental Illness			Venereal Disease		
Diverticulosis			Migraines			Other: _____		

Local Pharmacy: _____ Mail In: _____

Current Medications	**Dose**	**Frequency**

Allergies to Medication? □No □Yes

List: _____

Latex Allergy? □N □Y

Metal Allergy? □N □Y