

PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Peptide Practitioner, LLC. This form is used to collect information about new patients for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Gender:** Male Female Other

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Home Phone: _____ **Mobile Phone:** _____

Social Security Number: _____ **E-Mail:** _____

Ethnicity/Race: _____ **Weight:** _____ **Height:** _____

Primary Language: English Spanish Other: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse Name: _____ **Spouse Phone:** _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **E-Mail:** _____

Home Phone: _____ **Mobile Phone:** _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: HMO PPO Medicare Other: _____

Complete the following if you are **not** the policyholder for your primary insurance:

Insurance Policyholder: Spouse Child Parent Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: HMO PPO Medicare Other: _____

Complete the following if you are **not** the policyholder for your secondary insurance:

Insurance Policyholder: Spouse Child Parent Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

TREATING PHYSICIANS

Primary Care Physician: _____ Phone: _____

List all other active treating physicians:

Physician Name: _____ Specialty: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction:** _____
Allergy: _____ **Reaction:** _____
Allergy: _____ **Reaction:** _____
Allergy: _____ **Reaction:** _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose:** _____
Medication: _____ **Dose:** _____
Medication: _____ **Dose:** _____
Medication: _____ **Dose:** _____

FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description	Doctor	Location	Year

MEDICAL HISTORY

Have you ever had any of the following?

Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis Conditions	<input type="checkbox"/> Y <input type="checkbox"/> N	Male Hypogonadism	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N
Atrial Fibrillation	<input type="checkbox"/> Y <input type="checkbox"/> N	Infection Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N
Benign Prostatic Hyperplasia	<input type="checkbox"/> Y <input type="checkbox"/> N	Irritable Bowel Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Coronary Artery Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Menopause	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac Arrest	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines/Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N
Celiac Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Neuropathy	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Onychomycosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Organ Injury	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic Fatigue Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Pulmonary Embolism	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizure Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N
Drug/Alcohol Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Erectile Dysfunction	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Conditions	<input type="checkbox"/> Y <input type="checkbox"/> N
Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Gerd	<input type="checkbox"/> Y <input type="checkbox"/> N	Syndrome X	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
Hyperinsulinemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Wheat Allergy	<input type="checkbox"/> Y <input type="checkbox"/> N
Hyperlipidemia	<input type="checkbox"/> Y <input type="checkbox"/> N		

List any other medical problems that you have had:

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? Yes No

- If so, where? _____

How has the pain changed since it began? Increased Decreased Unchanged
How quickly did your current pain begin? Gradually Suddenly

How often does your pain occur? Constantly Occasionally Rarely

When is your pain at its worst? Morning Afternoon Evening Night

What are your current symptoms? _____

Check any of the following that describe your pain:

- | | | | | | | | |
|-------------|--------------------------|------------|--------------------------|----------------|--------------------------|-------------------|--------------------------|
| Aching | <input type="checkbox"/> | Numbness | <input type="checkbox"/> | Spasming | <input type="checkbox"/> | Throbbing | <input type="checkbox"/> |
| Cramping | <input type="checkbox"/> | Shock-like | <input type="checkbox"/> | Squeezing | <input type="checkbox"/> | Tingling | <input type="checkbox"/> |
| Dull | <input type="checkbox"/> | Shooting | <input type="checkbox"/> | Stabbing/Sharp | <input type="checkbox"/> | Tiring/Exhausting | <input type="checkbox"/> |
| Hot/Burning | <input type="checkbox"/> | | | | | | |

List any other health concerns that you would like us to know about:

SOCIAL HISTORY

Do you currently consume alcohol? Yes No

- How many drinks per week? _____

Do you currently smoke? Yes No

- What do you smoke? Tobacco Marijuana Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? Yes No

- What other drugs do you take? _____
- How often? Daily Weekly Occasionally Rarely

Do you drink caffeine? Yes No

- How many cups per day? _____

Are you sexually active? Yes No

How frequently do you exercise? Daily Weekly Occasionally Rarely

Are you on a special diet? Yes No

- What diet? _____

Complete the following if applicable:

Are you planning a pregnancy? Yes No

Are you pregnant now? Yes No

What type of contraception do you currently use? _____

When was your last menstrual cycle? _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- a) **Accurate Information.** I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- b) **Patient Rights and Responsibilities.** I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
- c) **Release of Medical Information.** I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
- d) **Consent for Treatment.** I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
- e) **Consent to Communication.** I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
- f) **Acknowledgment.** By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ Date: _____

Print Name: _____