WellSpring Family Practice

Patient Intake Questionnaire

This is one of the most important documents you will create for your medical providers. We will use the information you put on this form to create and complete your Clinical Summary. Please be as complete and accurate as possible. You may need to collect information from other sources to complete this form, such as your prescriptions, Immunization record and past medical records.

Demographics:

Name:_____ DOB:_____ SS#:_____
Ethnicity:_____ Race:_____
Gender: Male - Female
Address:_____
City:_____ State:____ Zip: _____Ph#1:_____Ph#2:_____
Employer:_____Ph#:_____
Emergency Contact Name:_____ Ph#:_____
Previous Primary Care Provider:_____ Ph#:_____

Allergies/Sensitivities:

Substance:	Reaction:	Onset Date:

Medications:

Medication/Supplement:	Dose:	Route:	Frequency:	Indication:	Active:

Habits/Substance Use:

Substance-Type:	Amnt:	Frequency:	Onset Yr:	Quit?:
Tobacco: cigarette, pipe, cigar, chew				
Alcohol: beer, wine, mixed drinks, liquor, whiskey				
Substance: marijuana, cocaine, meth				
Substance-benzodiazepine, opiates, other				
Activity: gambling, computers, television, games				

Past Medical History:

Disease Name:	Onset Date:	Treatments/Notes:

Past Surgical History:

Procedure Name:	Surgeon:	Date:	Reason for Procedure:

Family Medical History:

Disease Name:	Relative:	Age:	Treatments/Outcome:

Social History:

Marital Status: Status/Spouse Name/Date	
Children: Sex/Age	
Education: Level/Degree	
Occupation: Type/Name of Employer	
Diet: Type/Limitations	
Activity Level: Capacity/Exercise/Limits	
Code Status: Full Code/Life Support/Advance Directive	
Spiritual Belief System: Type/Active/Date	

Immunization History: (Please bring immunization record)

Immunization:	Last Booster/Shot Date:	What Facility:

Reproductive History: (For Women Only)

Age of 1st Menstruation: _____	Sexually Active? Yes / No	Pregnancy #: _____
Last Menstruation: _____	Birth Control=_____	Delivered #: _____
Cycle: Regular/Irregular	Monogamous? Yes / No	Premature #: _____
Duration of Menses=_____days	Hormones? Yes / No	Miscarried #: _____
Flow: Light/Medium/Heavy		Aborted #: _____

Review of Systems: (This portion of the form will need to be updated each visit to our office.)

Circle the symptoms that apply to you. Add any that you believe are not listed below.

Fatigue, Fever, Chills, Body aches, Sweating

Eye discharge, Eye pain, Change in vision, Dry Eyes, Flashing lights in vision

Masses, Pain, Headaches, Lightheadedness, Nasal congestion, Nose bleeding, Dental problems, Sore Throat, Breath odor, Ear pain, Snoring, Dry mouth

Breast lumps, Breast tenderness, Nipple discharge

Chest pain, Irregular heart beats, Rapid heart rates, Fainting, Lower extremity swelling, Looking blue, Aching when you walk, Slow heart rate

Shortness of breath, Wheezing, Cough, Hoarseness, Hemoptysis, Sputum/Phlegm

Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Abdominal pain, Jaundice, Black/Tarry Stool, Bloating, Bleeding, Change in Appetite

Urinary urgency, Frequency, Pain with urination, Urination at night, Blood in urine, Incontinence, Weak urinary stream, Irregular Menstruation, Hot flashes, Impotence

Rash, Itching, Dry skin, New skin lesions, Acne

Muscular weakness, Incoordination, Tingling, Numbness, Difficulty concentrating, Memory difficulties, Speech difficulties, Seizures, Tremors, Loss of balance

Joint pain, Joint swelling, Muscle pain, Muscle weakness, Muscle cramps, Skeletal deformity, Loss of function, Masses/Tumors

Increased Urine output, Increased Thirst, Hair loss, Constipation, Improper hair growth, Feeling cold, Feeling warm, Change in weight, Loss in height

Anxiety, Depression, Delusions, Feeling confused, Compulsive behaviors, Suicidal ideas, Homicidal ideas, Withdrawn, Angry

Easy bleeding, Easy bruising, Black spots on body, Enlarged lymph nodes, Tender lymph nodes

Sinus allergy symptoms, Allergic skin rash, Frequent Illness

_____ _____

Signature: Date: