

New Patient Health Intake Questionnaire

Please complete all sections of this questionnaire prior to your appointment. This form is designed to be printed once completed.

1. Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Biological Sex:

Phone Number:

Email Address:

Home Address:

2. Emergency Contact Information

Contact Name:

Relationship to Patient:

Contact Phone Number:

3. Medical History & Current Symptoms

Primary Reason for Visit Today:

List Any Diagnosed Medical Conditions:

List Any Past Surgeries and Dates:

Known Allergies (Medications, Food, Environmental):

Current Medications and Dosages:

4. Family Medical History

Please list any significant health conditions in your immediate family (e.g., heart disease, diabetes, cancer):

Mother's Side:

Father's Side:

5. Lifestyle & Social History

Tobacco Use (Type, Frequency, or "None"):

Alcohol Use (Frequency, Amount, or "None"):

Recreational Drug Use (Type, Frequency, or "None"):

Occupation:

6. Signature

By signing below, you certify that the above information is true and correct to the best of your knowledge.

Patient Signature: Date (MM/DD/YYYY):