Patient Intake Form

Today's Date: _____

Demographics:

Printed Name:_____ Social Security Number: _____

Address:_____City:_____State: _____Zip:_____

Date of Birth:_____ Circle One: Male Female

Mobile Phone:_____ Home Phone:_____

Email Address: _____ Work Phone: _____

Marital Status (circle one): Single Married Separated Divorced Widowed

If married, spouse's name _____ Spouse's occupation _____

In the event of an emergency, who can we call (give name and phone number):

_____

Are you employed (circle one): Yes No If yes, Where?_____

Preferred Language □ English □ Spanish □ Other Please Specify: _____

Race □White □ Black or African American □Asian □Hawaiian or Pacific Islander
□American Indian or Alaskan Native □ Refuse to Answer □ Other: _____

Ethnicity □ Hispanic or Latino □ Nonhispanic or Latino □ Refuse to Answer □Other _____

Do you have Insurance (circle one)? Yes No If yes, □ Medicaid □ Medicare □ Private

Do you have Secondary Insurance? Yes No If yes, please indicate _____

Do you currently have a Primary Care Physician (circle one): Yes No

If yes, Primary Care Physician's name _____

Medical History:

Current Medical Problems, if any: _____

Current Prescribed Medications:_____

Allergies: _____

Past hospitalization/surgeries: _____

Have you ever had psychiatric treatment? _____ When? _____

Have you ever attempted suicide? _____ When? _____

Have you ever overdosed from a drug? _____ When? _____

Check any of the following diseases/symptoms you have had:

___ Heart Disease	___ Tuberculosis	___ Head Injury	___ Hepatitis
___ Hypertension	___ Pneumonia	___ Dizziness/Fainting	___ Ulcer (stomach)
___ High Blood Pressure	___ Emphysema	___ Headaches	___ Pancreatitis
___ Heart Palpitations	___ Asthma	___ Limb Numbness	___ Liver Disease
___ Heart Murmur	___ Shortness of Breath	___ Limb Weakness	___ Kidney Disorder
___ Chest Pain	___ Thyroid disorder	___ Stroke	___ Kidney Stones
___ High Cholesterol	___ Diabetes	___ History of Seizures	___ Gall Stones
___ Arrhythmia	___ Gout	___ Epilepsy	___ Digestive Issues
___ Anemia	___ Rheumatic Fever	___ Mental Illness	___Eating disorder(s)
___ Bleeding Disorder	___ Urinary/Genital Problems	___ Cancer	___ Arthritis
___ HIV/AIDS	___ Ovarian Cysts	___ Hallucinations	___ Joint Pain
___ Communicable disease	___ STD	___ Withdrawal symptoms	___ Jaundice
___ Cancer	___ Prostrate Problems	___ Depression/Anxiety	___ Glaucoma

For Females Only: Menstrual Period (circle one): Regular Irregular Painful
Date of Last Menstruation: _____ Are you or could you be pregnant? _____

PATIENT SIGNATURE: _____ DATE: _____

Drug Abuse History: Fill out all that apply

Nicotine:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Alcohol:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Marijuana:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
LSD:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Mushrooms:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Amphetamines:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Steroids:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Inhalants:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Diet Pills:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Cocaine:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Crack:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Meth.:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Ecstacy:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Heroin:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
PCP:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Pain Killers:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Valium:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Sleeping Pills:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
I.V. Use:	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____
Other: _____	Current Amt: _____	Mos/Yrs of Use: _____	Last Use: _____	Route: _____

Longest Period of Abstinence: _____ Withdrawal Symptoms: _____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND FACTUAL. I authorize Ideal Option, PLLC providers to provide medical treatment to me in the office or in the hospital. I understand that I am financially responsible for all charges incurred for all services including (without limitation) any co-payment, deductible, or remaining balance amount after payment of possible insurance benefits at time of service. If the services provided by Ideal Option, PLLC are payable under an applicable government or commercial provided insurance benefit, I assign all payments and medical benefits directly to Ideal Option, PLLC for the services rendered by Ideal Option, PLLC that would otherwise be payable to me. I understand and agree that if no insurance coverage exists for all or part of a service(s) I receive from Ideal Option, PLLC or the insurance provider fails to pay Ideal Option, PLLC, I am financially responsible for the incurred charges. I further agree that I will pay all such incurred charges in accordance with Ideal Option, PLLC's payment policies and procedures. I understand that this form imposes no obligation for Ideal Option, PLLC to collect money on my behalf. I understand that Ideal Option has the right to forward unpaid accounts to a collections agency and I agree to bear all costs associated with Ideal Option's collection efforts on my account.

PATIENT SIGNATURE: _____ DATE: _____