



Union Physician Services

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: _____

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

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

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? _____

