The Manette Clinic Phone 360-621-2696
1100 Wheaton Way Suite F & G Bremerton WA 98310

New Patient Initial Intake Form

Name: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor
What would you consider your race: _____ Ethnicity: _____

What is your preferred language:_____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____Relation: _____

Phone #: (H) _____ (W) _____

Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

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Health History

PRESENTING PROBLEM: _____

_____

_____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Anemia	❑Arthritis	❑ Blood Disease	❑ Cancer
❑ Cataracts	❑ Colds(frequent)	❑ Diabetes	❑ Digestive Problems	❑ Eczema
❑ Epilepsy	❑ Headaches	❑Hepatitis	❑ Herniated Disc	❑ Herpes
❑ Hypertension	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease	❑ Lyme
❑ Miscarriage	❑ Pneumonia	❑ Prostate Problems	❑ Rheumatoid Arthritis	❑Stroke
❑ Tumors/Growth	❑ Tuberculosis	❑ Ulcers	❑ Urinary Tract Infections	❑Venereal Disease

Please list any medications you are currently taking (**Be sure to include dosage/frequency**)_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies (medication/food/insects,ect): _____

_____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes/Chew_____packs/day

Diet: ❑Junk Food (fast food & snacks) ❑ Processed (frozen or canned meals) ❑ Standard American (meats, potatoes, fats, desserts)
❑ Wholesome ❑ Vegetarian ❑ Raw Food ❑Other_____

Women's Health: Last menstrual cycle:_____

Number of Pregnancies:_____ Number of Children: _____ Number of Miscarriages: _____

Any sexual difficulties?_____

Men's Health: Last Prostate Exam: _____

Any sexual difficulties? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

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Review of Systems

Please mark if you have experienced any of these symptoms within the last month:

Y	N	Neurological
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention