1100 Wheaton Way Ste F, Bremerton, WA 98310
Phone (360) 621-2696 | Fax (844) 602-4646
www.TheManetteClinic.com

# New Patient Initial Intake Form

Please fill out entire form. Any line that does not apply to you, please mark "N/A."
Please provide the office with a current picture identification and insurance card(s) to copy.

Name: (Last) ____________________________________ (First)________________________________ (MI)______

Nickname: __________________________________

Mailing Address:__________________________________________________________________________________
Street/P.O. Box City/State Zip Code

Physical Address: _________________________________________________________________________________
Street City/State Zip Code

Email: __________________________________________ Preferred Communication (circle): Email Home Cell

Phone: (Home)_________________________________ (Cell)________________________________________

(Work)_________________________________ Can we call you at work? (circle): Yes No

Date of Birth: _________________ SSN#:____________________________ Sex (circle): Male Female

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

Race (circle): American Indian/Alaska Native Black/African American Pacific Islander White Asian Other

Are you of Hispanic or Latino/a origin? (circle) Yes No What is your preferred language?______________

Occupation: _________________________________ Employer: ______________________________________

How did you hear about our practice? _____________________________________________________________

Emergency Contact: Name: __________________________________________ Relation:________________

Phone: (Home) ______________________ (Cell) _______________________ (Work) ___________________

## INSURANCE INFORMATION

Do you have health insurance? (circle) Yes No Name of Primary Carrier: __________________________

Do you have secondary insurance? (circle) Yes No Name of Secondary Carrier: ________________________

Policy Holder's Name:_______________________________ Relationship to Patient: _____________________

Policy Holder's Date of Birth: ________________ Policy Holder's SSN#: _____________________________

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# HEALTH HISTORY

Presenting Problem:______________________________________________________________

Please circle 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 | Ulcers | Stroke |
| Tumors/Growth | Tuberculosis | UTI | Rheumatoid Arthritis | Venereal Disease |

Please list or attach any medications you are currently taking (be sure to include dosage & frequency):_____________________

_____________________________________________________________________________

Please list or attach any supplements you are currently taking (vitamins/herbs/minerals):_________________________________

_____________________________________________________________________________

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

_____________________________________________________________________________

Please list or attach any allergies (medication/food/environmental, latex, etc):__________________________________________

_____________________________________________________________________________

Do you exercise? (circle): Never Daily Weekly Walks Runs Swims

Smoking Status (circle): Current Smoker Former Smoker Never a Smoker

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol ____ drinks/week Cigarettes/Chew ____packs/day Marijuana_____times/week

Diet (mark): ___ 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: ________________________ Last Mammogram:________________________________

Number of Pregnancies: _____________ Number of Children: ________________ Number of Miscarriages: __________

Last Colonoscopy: ___________________________ Any sexual difficulties? ___________________________________________

History of abnormal paps? (circle) Yes No If yes, when?_______________________________________________________

**Men's Health**: Last Prostate Exam: _________________________ Last Colonoscopy:___________________________________

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:**_____________________________________________________________ **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 |
| ___ | ___ | Head injury |
| ___ | ___ | Seizure |
| ___ | ___ | Stroke |
| ___ | ___ | Disc disease |
| | | **Eyes/Ears/Nose/Throat** |
| ___ | ___ | Altered taste/smell |
| ___ | ___ | Night blindness |
| ___ | ___ | Sore throat |
| ___ | ___ | Gingivitis |
| ___ | ___ | Nose bleeds |
| ___ | ___ | Sneezing fits |
| ___ | ___ | Ear infections |
| ___ | ___ | Sinus infections |
| ___ | ___ | Stuffy nose |
| ___ | ___ | Post nasal drip |
| ___ | ___ | Ear pain |
| ___ | ___ | Hearing change |
| ___ | ___ | Ringing in ears |
| | | **Cardiovascular** |
| ___ | ___ | Chest pain |
| ___ | ___ | Palpitations – racing heart beat |
| ___ | ___ | Swelling in hands/feet |
| ___ | ___ | Anemia |
| ___ | ___ | Shortness of breath |
| ___ | ___ | Exercise intolerance |
| ___ | ___ | Chest tightness |
| | | **Respiratory** |
| ___ | ___ | Recurrent respiratory infections |
| ___ | ___ | Asthma |
| ___ | ___ | Chest congestion |
| ___ | ___ | Wheezing |
| ___ | ___ | Lung disease |
| ___ | ___ | Cough |

| 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 |
| ___ | ___ | Irregular periods |
| ___ | ___ | Menopause |
| | | **Emotional/Mental** |
| ___ | ___ | Depression |
| ___ | ___ | Anxiety |
| ___ | ___ | Mood swings |
| ___ | ___ | Irritability |
| ___ | ___ | Memory loss |
| ___ | ___ | Confusion |
| ___ | ___ | Mania |
| ___ | ___ | Suicidal thoughts |
| | | **Energy** |
| ___ | ___ | Fatigue |
| ___ | ___ | Hyperactivity |
| ___ | ___ | Restlessness |
| ___ | ___ | Insomnia |
| ___ | ___ | Decreased libido |
| ___ | ___ | Stress |
| | | **Weight** |
| ___ | ___ | Decreased appetite |
| ___ | ___ | Weight gain |
| ___ | ___ | Inability to lose weight |
| ___ | ___ | Food cravings |
| ___ | ___ | Binge eating |
| ___ | ___ | Water retention |