The Manette Clinic
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 to the best of your ability.

BASIC INFORMATION

Name: (Last) _____ (First)_____ (MI)_____

Nickname: _____ **Date of Birth**: _____ **SSN#**:_____

Sex : Male Female Unknown

Gender Identity: Male Female Male-to-Female Female-to-Male Genderqueer Other

CONTACT DETAILS

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

Physical Address: _____
Street City/State Zip Code

Email: _____

Phone: (Home)_____ (Cell)_____

(Work)_____ **Can we call you at work**? YES NO

Preferred Communication: EMAIL HOME CELL

ADDITIONAL INFORMATION

Marital Status : Single Married Divorced Widowed Separated Minor

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

Are you of Hispanic or Latino/a origin? YES NO **What is your preferred language**?_____

Employment Status : Employed Non-Employed Full-time Student Part-time Student

Occupation: _____ **Employer**: _____

How did you hear about our practice? _____

Emergency Contact: Name: _____ Relation:_____

Phone: (Home) _____ (Cell) _____ (Work) _____

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INSURANCE INFORMATION

Do you have health insurance? (CIRCLE) YES NO If No, skip to the next section.

Primary Insurance Name of Carrier: _____

ID #: _____

Policy Holder's Name: _____ **Relationship to Patient**: _____

Do you have secondary insurance? YES NO **Name of Carrier:** _____

ID #: _____

Policy Holder's Name: _____ **Relationship to Patient:** _____

***If your insurance is Tricare of any kind, please also include:**

Policy Holder's Date of Birth: _____ **Policy Holder's SSN#:** _____

CONTACT DETAILS for Legal Guardian/POA

I am the legal Guardian or POA for this patient. In addition, I have a notarized copy of the Guardianship or POA paperwork that confirms this and will provide The Manette Clinic with a copy of this document.

CIRCLE: YES NO If No, skip to the next section.

Name: (Last) _____ (First)_____ (MI)___

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

Billing Address (If different than mailing address. This address is where we would send patient billing invoices.)

_____
Street City/State Zip Code

Email: _____

Phone: (Home)_____ (Cell)_____

(Work)_____ **Relation to patient:** _____

Other INDIVIDUALS to be listed as contacts for this patient (include name, contact info and relation to patient)**:**

1. _____
PRINTED NAME PHONE NUMBER EMAIL ADDRESS RELATION TO PATIENT

2. _____
PRINTED NAME PHONE NUMBER EMAIL ADDRESS RELATION TO PATIENT

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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? Never Daily Weekly Walks Runs Swims

Smoking Status? 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 :
___ 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: _____ History of abnormal pap(s)? (circle) Yes No When?_____

Men's Health: Last Prostate Exam: _____ Last Colonoscopy:_____

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

SIGNATURE:_____RELATION:_____ DATE:_____

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Review of Systems

Please mark if you have experienced any of these symptoms:

Y	N	Neurological
__	__	Migraines
__	__	Headaches
__	__	Slurring of speech
__	__	Head injury
__	__	Seizure
__	__	Stroke
__	__	Disc disease

Y	N	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

Y	N	Cardiovascular
__	__	Chest pain
__	__	Palpitations – racing heart beat
__	__	Swelling in hands/feet
__	__	Anemia
__	__	Shortness of breath
__	__	Exercise intolerance
__	__	Chest tightness

Y	N	Respiratory
__	__	Recurrent respiratory infections
__	__	Asthma
__	__	Chest congestion
__	__	Wheezing
__	__	Lung disease
__	__	Cough

Y	N	Musculoskeletal
__	__	Joint pain
__	__	Arthritis
__	__	Chronic pain
__	__	Muscle aches
__	__	Broken bones
__	__	Artificial joints

Y	N	Weight
__	__	Decreased appetite
__	__	Weight gain
__	__	Inability to lose weight
__	__	Food cravings
__	__	Binge eating
__	__	Water retention

Y	N	Skin
__	__	Eczema
__	__	Dermatitis
__	__	Excessive sweating
__	__	Rashes
__	__	Brittle nails
__	__	Hair loss
__	__	Easy bruising
__	__	Increased bleeding
__	__	Numbness/tingling

Y	N	Genitourinary
__	__	Uterine fibroids
__	__	Ovarian cysts
__	__	Cancer (breast, ovarian, prostate, uterine)
__	__	Prostate problems
__	__	Irregular periods
__	__	Menopause
__	__	Erectile Dysfunction
__	__	Sexual Difficulties

Y	N	Emotional/Mental
__	__	Depression
__	__	Anxiety
__	__	Mood swings
__	__	Irritability
__	__	Memory loss
__	__	Confusion
__	__	Mania
__	__	Suicidal thoughts

Y	N	Energy
__	__	Fatigue
__	__	Hyperactivity
__	__	Restlessness
__	__	Insomnia
__	__	Decreased libido
__	__	Stress

Y	N	GI
__	__	Stomach Pains or Cramping
__	__	Constipation
__	__	Reflux or Heartburn
__	__	Bloating
__	__	Gas
__	__	Nausea or Vomiting
__	__	Blood in stool
__	__	Black, tarry stool
__	__	Diarrhea