Aaron
Boone
DO
and
Associates,
PLLC

**PATIENT INTAKE FORM (HISTORY FORM)**

Patient Name:____________________________________

Preferred Name:__________________________________

Gender _________. Date of Birth:________________ Age:_____. Today's Date_______________

Who Referred You to Our Clinic?: _________________________________________________

Name of Primary Care Physician: __________________________________________________

Place of Employment: __________________________________________________________

Occupation: __________________________________________________________

Office Use Only: VITALS: BP_____/_______ Pulse:________ Weight________ Height_________

Did an accident cause your complaint (circle). YES NO
Date of accident or injury related to your complaint: __________________
Is there ongoing litigation with your injury (circle): YES NO
Workers Compensation (circle): YES NO

CONTEXT OF ACCIDENT (Please Circle):

No Injury / Injury / Sports Injury / Motor Vehicle Accident / Other: ________________________

ChiefComplaint/Concern______________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

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MEDICATIONS: (Please include dose and frequency)

| | |
|---|---|
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| | |
| | |
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| | |
| | |
| | |
| Drug Allergies: | |

PAST MEDICAL HISTORY (Significant Medical Problems. Please include all hospitalizations and surgeries.)

| DATE | PROBLEM/SURGERY |
|---|---|
| | |
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SOCIAL HISTORY

Do you currently smoke/use tobacco or have you used in the past: (Circle One.). YES. NO
If yes: (Circle): Cigarettes. E-Cigarettes. Pipes. Cigars.
Cigarettes: How many cigarettes/packs do you smoke in one day ______________________________
Pipes/Cigars: How many per day? _________________________________________________________
When did you quit? (If applicable)

Do you drink alcoholic beverages? (Please Circle). YES NO
Type of Alcohol: Beer. Liquor. Wine.
Number of Drinks per day? __________________________

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FAMILY HISTORY: (Includes Diabetes, High Blood Pressure, Heart Attacks, Cancers, Strokes)

| RELATIONSHIPS | AGE | SICK | DECEASED | CAUSE OF SICKNESS OR DEATH |
|---|---|---|---|---|
| FATHER | | | | |
| MOTHER | | | | |
| BROTHER(S) | | | | |
| SISTER(S) | | | | |
| SPOUSE | | | | |
| CHILD(REN) | | | | |
| | | | | |

Marital Status: Single. Married Divorced. Widowed. Cohabitation
Children : YES. NO
Number of sons: _______________
Number of daughters:__________