PATIENT INTAKE FORM

Name**:**		
Street Address**:**		
City:	Postal Code**:**	
Phone**:** (home)	(Cell)	(Work)
Email Address:	Occupation:	
Social Security Number:		
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? Yes ☐ No ☐		
Would you like to receive South Florida Injury and convenient Care texts regarding appointment Information? Yes ☐ No ☐		
Gender*(circle)*: M F	Date of Birth**:**	
Family Doctor**:**		
Preferred Pharmacy**:**	Phone Number**:**	

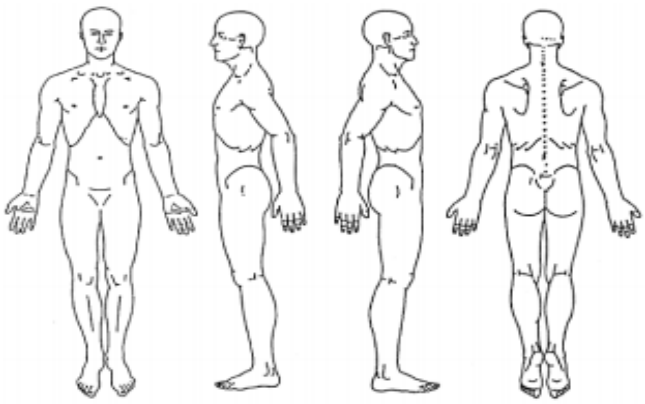
REASON FOR VISIT/ INJURIES:

PAIN RATING:

On a Scale of 0-10, rate your pain: (Please circle the number that best describes your pain)

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10



MEDICAL HISTORY

Height: _____ Weight: _____

Do you have any of the following?

Diabetes?	Yes	No
Heart Trouble?	Yes	No
Epilepsy?	Yes	No
High Blood pressure?	Yes	No
Circulation problems?	Yes	No
Osteoporosis?	Yes	No
Bowel/Bladder Problems?	Yes	No
AIDS/HIV positive?	Yes	No
Have you ever had cancer?	Yes	No
Have you ever experienced dizziness or blackouts?	Yes	No
Sudden weight loss?	Yes	No
Breathing problems?	Yes	No
Are you pregnant?	Yes	No
Recent surgery?	Yes	No
Arthritis?	Yes	No

Describe any other health problems:

_____

_____

List of Past Surgeries:

_____

List any allergies:

_____

List all medications you are taking:

_____

Have you had any X-RAYS/MRI taken related to this Injury? YES NO

If so, Where? _____

Right or Left Handed? R L

SOCIAL HISTORY:

___Smoker ___Non-Smoker
___Drink Alcohol How much? _____
___Does not Drink Alcohol

Is this injury related to a motor vehicle accident/Slip and Fall: Yes No

Motor Vehicle Accident Patients

(*Please fill out this section*)

Insurance Company *(Branch Office if applicable)*	
Address	
Telephone Number	
Fax Number	
Adjuster's Name	
Date of Accident	
Policy Number	
Claim Number	
Name of Policy Holder *(If different from claimant)*	