PATIENT INFORMATION

Last Name _____First Name _____ Middle_____

Address _____ City _____ State_____ Zip _____

Phone ( )_____ SS# _____ Birth date _____ Age_____

Insured Name_____

Insured Birth date _____

Is it okay to leave a message on the phone number that you have provided? Yes No

If no, please state method of contact where we can leave a message if we need to reach you:_____

Email address: _____

Is it okay to send you a message by email? Yes No

Would you like to receive appointment reminders via email? Yes No

Is it okay to send you a message via text? Yes No

If yes, please provide cell number, if different then above:_____

The following information is now being required by insurance companies as part of an initial intake:

Have you been vaccinated for pneumonia? Yes / No

Have you had a flu shot for the current flu season? Yes / No

What is your smoking status: Never smoked Current smoker (____ packs per day) Former smoker

Have you had two or more falls within the past year? Yes / No

Within the past 2 weeks:

1. Have you been bothered by feeling down, depressed, or hopeless? Yes / No

2. Have you often been bothered by little interest or pleasure in doing things? Yes / No