TWIN CREEKS HEALTH INTAKE FORM

Name____
Date____________________

Address____
City__________________ State____ Zip___________

Home Ph ________________ Cell Ph________________ Work Ph _________________

Social Security______________________________ Email address:
____

DOB_____________ Age_______ Sex_______
Number of children:_______________ Status M S W D

Employer Name_____________________________________
Occupation______________________________________

Emergency Contact ____________________________________ Ph ________________

Person responsible for this account___________________________
Referred By ________________________________

What is your major complaint?

____

How long have you had this condition? ____________________________________
Have you had this in the past?_____________

Is this work related? _____ Is this related to an accident?_______
If so, when: _________________________________

What activities aggravate your condition?

____

Is this condition getting progressively worse? ____yes ____no
____constant ____ comes and goes

Is this condition interfering with your:
___ work ___sleep ___ daily routine other__________________________

How long has it been since you really felt good?

____

List surgical operations _____________________________
List medications you are taking: ________________________

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Other Doctors Seen For This Condition:
___ MD ___DC ___ DO ___DDS Other__________________________

Doctor's Name ____
Diagnosis ____

Any other previous medical conditions:
____

Insurance Information

Insurance Name____ Insured Name___________________________________

Policy # ______________________________Group #________________________________Phone # ______________________

Additional Insurance Company Name __________________________ Insured Name __________________________________

Policy # ______________________________Group# ______________________________ Phone# ______________________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fess for professionally services rendered to me will be immediately due.

Patient's Signature ____ Date :_____________