New Patient Intake Form

Please complete this form thoroughly to help us provide the best possible care.

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1. Personal Information

- **Name:** _____
- **Date of Birth:** _____
- **Age:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Address:** _____
- **City:** _____ State: _____ ZIP: _____
- **Preferred Phone Number:** _____
  ☐ Home ☐ Mobile ☐ Work
- **Email Address:** _____
- **Preferred Contact Method:** ☐ Phone ☐ Email ☐ Text

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2. Emergency Contact Information

- **Name:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____
  ☐ Home ☐ Mobile ☐ Work
- **Alternate Phone Number:** _____

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3. Health Insurance Information

- **Primary Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Policyholder's Name:** _____
- **Relationship to Patient:** _____
- **Secondary Insurance (if applicable):** _____

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4. Pharmacy Information

- **Pharmacy Name:** _____
- **Pharmacy Address:** _____
- **Pharmacy Phone Number:** _____

FERRARO
BRAIN AND SPINE

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5. Advanced Directives or Power of Attorney

- **Do you have an Advanced Directive?** ☐ Yes ☐ No
- **Do you have a Power of Attorney for Healthcare Decisions?** ☐ Yes ☐ No
  (If yes, please provide a copy for our records.)
- **Name of Healthcare Proxy:** _____
- **Phone Number:** _____

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6. Medical History

Primary Reason for Visit: _____
Referring Physician (if applicable): _____
Primary Care Physician: _____

- **List of Current Medications (include dose and frequency):**

  _____

- **Allergies:**
  ☐ None
  ☐ Medications: _____
  ☐ Food: _____
  ☐ Other: _____

- **Past Surgeries (list type and date):**

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

- **Chronic Conditions (check all that apply):**

Diagnosis	Diagnosis	Diagnosis
☐ Hypertension	☐ Diabetes Mellitus Type 2	☐ Hyperlipidemia
☐ Obesity	☐ Depression	☐ Anxiety Disorders
☐ Gastroesophageal Reflux	☐ Hypothyroidism	☐ Asthma
☐ Chronic Back Pain	☐ Osteoarthritis	☐ Chronic Kidney Disease
☐ Anemia	☐ COPD (Chronic Bronchitis)	☐ Sleep Apnea
☐ Coronary Artery Disease	☐ Atrial Fibrillation	☐ Congestive Heart Failure
☐ Migraine	☐ Seasonal Allergies	☐ Irritable Bowel Syndrome
☐ Alzheimer's Disease	☐ Stroke (CVA)	☐ Parkinson's Disease
☐ Attention Deficit Disorder	☐ Gout	☐ Psoriasis
☐ Rheumatoid Arthritis	☐ Chronic Sinusitis	☐ Endometriosis
☐ Polycystic Ovary Syndrome	☐ Hepatitis C	☐ Fibromyalgia
☐ Eczema	☐ Peptic Ulcer Disease	☐ Hyperthyroidism
☐ Diverticulitis	☐ Gallstones	☐ Crohn's Disease
☐ Ulcerative Colitis	☐ Celiac Disease	☐ Chronic Fatigue Syndrome
☐ Panic Disorder	☐ Bipolar Disorder	☐ Epilepsy
☐ Substance Use Disorder	☐ Alcohol Use Disorder	☐ HIV/AIDS
☐ Multiple Sclerosis	☐ Lupus (SLE)	☐ Peripheral Neuropathy
☐ Chronic Pain Syndrome	☐ Cancer (any type)	☐ Venous Insufficiency

☐ Other: _____

- **Family Medical History**

  Mother: _____

  Father: _____

  Siblings: _____

  Paternal Grandparents: _____

  Maternal Grandparents: _____

  Children: _____

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7. Review of Systems

Please check any symptoms you are currently experiencing:

- **General:** ☐ Fever ☐ Weight loss ☐ Fatigue
- **Neurological:** ☐ Headaches ☐ Dizziness ☐ Seizures ☐ Weakness
- **Musculoskeletal:** ☐ Back pain ☐ Neck pain ☐ Joint stiffness
- **Cardiovascular:** ☐ Chest pain ☐ Palpitations
- **Respiratory:** ☐ Shortness of breath ☐ Cough
- **Gastrointestinal:** ☐ Nausea ☐ Vomiting ☐ Difficulty swallowing
- **Genitourinary:** ☐ Incontinence ☐ Difficulty urinating
- **Other Symptoms:** _____

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8. Consent and Authorization

By signing below, I certify that the information provided is accurate and complete to the best of my knowledge. I consent to the use of this information for medical treatment, billing, and communication as outlined in the clinic's privacy policies. I acknowledge that I have reviewed the clinic's financial policies and understand my responsibilities.

Signature of Patient or Legal Guardian: _____
Date: _____

Witness Signature: _____
Date: _____