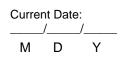
9015 Adams Ln Suite C Temple, TX 76502 (254) 307-2896





Patient Intake Form

Name:			
First	Middle	Last	
Birthdate:// M D Y	Age:	Sex:	
Email:		May we email you reminders: Yes	No
Address:			_
City:	State:	Zip Code:	_
Phone number:	Current O	ccupation:	_
Are you enrolled in Medicare: Yes	No Preferred	Pharmacy:	_
Family Physician Name and Clinic N	Name:		_

What do you want to accomplish at today's visit?

What body part(s) are you having issues with?

Is this a new issue?

When did it first start?



What makes your issue feel worse?

What makes it feel better?

What treatments have you tried?

Did they help?

Where were you treated?

Please list all medical conditions:

Please list all medications and supplements you currently take:

Please list all prior surgeries:

Do you currently or have you ever had cancer of any kind?

Do you use any nicotine products?

Do you consume alcohol?

Do you use any drugs?

Is there any other information that your provider should be aware of?