Patient Intake Form

Name: _____ Date of Birth: ____/____/____ Date ____/____/____

Age: ____ Single Married Email Address: _____

Cell number: _____ Home number: _____ Emergency Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about our office? Referred by: _____

Medical Physician Nurse Practitioner Physician Assistant Dentist Physical Therapist
The Phone Book Magazine Ad Website Other: _____

Medication's

Please list all **allergies to medications: (**Example: Penicillin, Sulfa, Tetracycline, Novocaine, Procaine)

Please list all **prescription medications**: (Example: Prozac, Atenolol, Lipitor, etc.)

Please list all **over the counter medications**: (Example: Tums, Advil, Tylenol, Aspirin, etc.)

Please list all **vitamins, minerals, herbs** and/or additional nutritional supplements:

Health Concern's

What are your health concerns that you would like to discuss with Dr. Hardy?
(Please list in order of the most important to the least important).

1 _____ # 2 _____ # 3 _____

Is this a recent problem, which is 3 months or less in duration? Yes

Is this a long-term problem, which is more that 3 months in duration? Yes

How long have you had this complaint? ____ # day's ____# week's ____ # month's ____# year's

Is your problem getting? Better Worse Staying the same

Has this problem been diagnosed by a Medical Doctor?
Yes; Diagnosis: _____
No

Please check additional healthcare professionals you are currently seeing or have seen in the past for these concerns:
Medical Physician Nurse Practitioner Dentist Chiropractor Physical Therapist
Other: _____

Name: _____ Specialty: _____

Types of treatments received: _____

Did treatments benefit you? Yes Not Much No

Past and/or Current Medical History

Measles	Tuberculosis	Hepatitis	Digestive Disorders
Mumps	Venereal Disease	Diabetes	Hormonal Disorders
Chickenpox	Epilepsy	High Blood Pressure	Reproductive Disorders
Whooping cough	Cancer	Low Blood Pressure	Osteoporosis
Scarlet Fever	Glaucoma	Asthma	Anemia
Diptheria	Mitral Valve Prolapse	Ulcer	Chronic Fatigue
Smallpox	Stroke	Heart Disease	Fibromyalgia
Polio	Hernia	Thyroid Disease	Headaches
Pneumonia	Bleeding tendency	Kidney Disease	Neck pain
Rheumatic Fever	AIDS or HIV	Lung Disease	Back pain

Other / Surgery: _____

General Question's

What are your expectations from us?

What specific improvements would you like to see?

What do you think is a realistic timeframe to see changes in your pain and/or health condition?

How has your pain and/or health condition(s) affected your quality of life, family, job, finances or relationships?

Are your spouse and/or family supportive of you seeking care in our office? Yes No

I want a temporary form of symptom relief, knowing that my pain and/or health condition will return.

I want to address the underlying cause(s), of my pain and/or health condition(s), which will require more time, finance(s) and effort on my part which in turn will greatly improve my life.

I want Dr. Hardy to make whatever recommendations that is best for me.

I am not sure right now.

Commitment Level to Improving My Health

What level of commitment do you have to getting better?

This includes lifestyle changes, financial investment, return appointments as needed.
0 – 25% 25 – 50% 50 – 75% 75 – 100%

What are you ***not willing*** to do or ***not willing*** to give up to feel better and/or improve your life?

Authorization for Examination, Treatment and/or Consultation

The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I authorize Dr. Brian N. Hardy and/or staff to perform the consultations, examinations and/or treatments as necessary.

I understand Dr. Brian N. Hardy has the right to accept or decline me as a patient.

I understand and agree to the information provided on these pages.

_____ _____
Signature of Patient and/or Guardian Date

Office Policy

If accepted, as a patient, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without Dr. Hardy's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care.

_____ _____
Signature of Patient and/or Guardian Date

Cancellation Policy

Our Patients are very important to us!

Missed appointments are costly and take away valuable appointment time from others.

Therefore, we ask for your consideration in contacting our office at least 24 hours prior to your scheduled appointment for any changes or cancellations.

This cancellation fee must be paid, prior to making any additional appointments and cannot be billed to your insurance company.

We understand that certain circumstances can arise and the cancellation policy may be waived and left up to our discretion.

Thank You

_____ _____
Signature of Patient and/or Guardian Date

Office Use Only

Above-mentioned individual was (accepted) for treatment.
Above-mentioned individual was (declined) for treatment.

Above-mentioned individual was (referred to) another healthcare professional.

Referred to: _____

_____ _____
Signature of Dr. Brian N. Hardy and/or Staff Date