NEW PATIENT INTAKE FORM

C.S. Leung Rehabilitation Medicine

Patient Information

Name:_____Today's Date:_____

Address:_____

Email:_____Zip Code_____

Home Telephone #:_____Cell #:_____

Birth Date:_____ Age:_____Sex:_____

Emergency Contact:_____Relationship:_____

How did you hear about us?

_____ Other_____

Insurance:

Name of Insurance_____ Member ID:_____ Group ID: _____

Name of Insured _____ Self ◉ Spouse ◯

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Occupation:_____

Family Physician's Name:_____Telephone #: _____

Physician's Address:_____

Pharmacy (that you want us to send prescriptions to**):** _____

1. MEDICAL INFORMATION:

2. What problem are you being seen for today? Please describe briefly.

3. _____

When and how did your problem begin?

_____

Was it a result of a work-related injury or car accident? YES◯ NO◯

Have you seen any of the following for your problem. Check who you have seen.

☐ Physician ☐ Chiropractor ☐ Acupuncture ☐ Physical Therapist

If so, where did you receive treatment? For how long and did you improve?_____

_____

Have you had surgery in the past? YES◯ NO◯ If so, what type of surgery?

_____

Are you pregnant? YES◯ NO◯

Please write down any medications or herbal supplements you are taking.

_____

_____

_____

_____

4. Do you have any allergies/allergies to medication? If so, please list them:

_____

Medical History: Complete for each family member, placing a check in the appropriate box:

	Self	Mother	Father
Blood Disorder/Anemia			
Diabetes			
Cancer			
Tumors			
High Blood Pressure			
Kidney or Bladder Disorder			
Stomach or Intestinal Disorder			
Drug Abuse			
Hepatitis C			
Heart Disease			
Stroke			
Depression/Mental Illness			
HIV			
Other Disease/Illness			

I attest that the information I supplied is correct. I understand that I may be financially liable for medical bills if the information supplied is incorrect, if claims are not covered by my insurance / if I fail to report a work related or auto-accident injury / for any out of pocket expenses including deductibles, coinsurance & copays.

Signature _____