

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? (Circle the one that applies)

Patient Referral ZocDoc Insurance Website Newspaper OTHER _____

Insurance:

Name of Insurance _____ Member ID: _____ Group ID: _____

Name of Insured (Indicate self or 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): _____

MEDICAL INFORMATION:

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

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. Circle who you have seen.

Physician Chiropractor Acupuncture Physical Therapist

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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.

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

Medical History: Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father
Blood Disorder/Anemia			
Diabetes			
Cancer or 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 _____