PATIENT INTAKE FORM

Alisa Alayan M.D., Inc.

GENERAL

Patient Name	Last	First	Middle	Today's Date (MM/DD/YY)
Social Security #		Driver's License / State Issued	Gender: Male ☐ Female ☐	Date of Birth (MM/DD/YY)

Email Address

Name of Spouse / Partner

Home Address

Primary Telephone — Cell ☐ Home ☐ Work ☐

Secondary Telephone — Cell ☐ Home ☐ Work ☐

Emergency Contact, Your Relationship, & Primary Telephone

EMPLOYMENT

Employer & Job Title

Is this a work related injury? Yes ☐ No ☐	Work Comp Insurance Carrier & Claim #
If yes, has your employer been notified? Yes ☐ No ☐	Claim Adjuster & Telephone

PHARMACY

Pharmacy Name, Address & Telephone

PRIMARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

SECONDARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary.
I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsibility for ALL services provided.

Patient Name________________________________ **Signature**______________________ **Date**____/____/____

MEDICAL HISTORY

Alisa Alayan M.D., Inc.

GENERAL

Name *Last Name* *First Name* *M.I.*				Today's Date (MM/DD/YYYY) / /
Gender ☐ Male ☐ Female	Height	Weight	Age	Primary Care Doctor & Phone

CURRENT PROBLEM

What part of your body are you being seen for today?

When did the problem start: ☐ Over Time (Duration:__________________) ☐ Injury (Date of Injury:_____________________)

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakness? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:__________________☐ Other: ____________

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable

MEDICAL HISTORY: LIST ALL

Medical problems:

Medications:

Supplements:

Surgeries:

Drug allergies (include reaction):

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed Name:

Did you have a drink containing alcohol? ☐ Yes☐ No If yes, drinks per week:

Do you use tobacco products? ☐ No ☐ Yes If yes, how many packs per day?

Do you use recreational drugs? ☐ No ☐ Yes Describe:

Patient Name____Signature________________________________Date_____/_____/ _____

MEDICAL HISTORY

Alisa Alayan M.D., Inc.

HEALTH REVIEW (Do you have any of the following?)

GENERAL			GASTROINTESTINAL		
Have you been in good general health most of your life	☐ No	☐ Yes	Vomiting blood or food	☐ No	☐ Yes
Any allergies, including medication	☐ No	☐ Yes	Gallbladder disease	☐ No	☐ Yes
Any recent weight gain	☐ No	☐ Yes	Liver trouble	☐ No	☐ Yes
SKIN			Hepatitis	☐ No	☐ Yes
Skin Disease	☐ No	☐ Yes	Painful bowel movements	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Black stools	☐ No	☐ Yes
Hives, eczema or rash	☐ No	☐ Yes	Hemorrhoids or piles	☐ No	☐ Yes
Frequent infections or boils	☐ No	☐ Yes	Recent changes in bowel habits	☐ No	☐ Yes
Abnormal pigmentation	☐ No	☐ Yes	Heartburn or indigestion	☐ No	☐ Yes
HEAD, EYES, EARS, NOSE, THROAT			***GENITOURINARY***		
Eye diseases or injury	☐ No	☐ Yes	Loss of urine	☐ No	☐ Yes
Wear glasses	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes
Double vision	☐ No	☐ Yes	Night time urinating	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Kidney trouble / Kidney stones	☐ No	☐ Yes
Itching eyes or nose	☐ No	☐ Yes	***LOCOMOTOR - MUSCULOSKELETAL***		
Sneezing or runny nose	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes	Varicose veins	☐ No	☐ Yes
Chronic sinus trouble	☐ No	☐ Yes	Weakness of muscles or joints	☐ No	☐ Yes
Ear disease	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes
Impaired hearing	☐ No	☐ Yes	Pain in calves or buttocks on walking, relieved by rest	☐ No	☐ Yes
Dizziness or transient episodes of unconsciousness	☐ No	☐ Yes	***NEURO - PSYCHIATRIC***		
RESPIRATORY			Ever had psychiatric care	☐ No	☐ Yes
URI (cold) now	☐ No	☐ Yes	Ever been advised to see a psychiatrist	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes
Chronic of frequent cough	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes	Paralysis	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	***ENDOCRINE***		
CARDIOVASCULAR			Diabetes	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Shortness of breath with walking or lying down	☐ No	☐ Yes	Hormone therapy	☐ No	☐ Yes
Heart trouble or heart attacks	☐ No	☐ Yes	Any change in hat or glove size	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Any change in hair growth	☐ No	☐ Yes
Swelling of hands, feet or ankles	☐ No	☐ Yes	Become colder than before or skin become dryer	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	***HEMATOLOGICAL***		
NECK			Slow to heal after cuts	☐ No	☐ Yes
Stiffness	☐ No	☐ Yes	Blood disease	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
			History of blood clots	☐ No	☐ Yes
			Bleeding problems	☐ No	☐ Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Suicide	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Mental illness	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Bleeding tendency	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Gout or other arthritis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hereditary defects	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Name______________________________ **Signature**____________________ **Date**____/____/____