New Patient Medical Intake Form

Patient Details

- **Name: _____**
- **Date of Birth: _____ / _____ / _____**
- **Address: _____**
  City: _____ State: _____ ZIP: _____
- **Phone Number: _____**
- **Email Address: _____**

Medical Information

- **Primary Physician: _____**
- **Reason for Visit: _____**
- **Allergies: _____**
- **Medications: _____**
- **Past Surgeries or Hospitalizations:**

Health Conditions

Please check any conditions you have or had in the past:

[ ] Asthma [ ] Diabetes [ ] Arthritis [ ] Anxiety

[ ] Depression [ ] Heart Disease [ ] Cancer [ ] Other: _____

Family History

Condition	Relationship	Age Diagnosed	Additional Details

Consent

I authorize the release of my medical information for treatment purposes.

Signature: _____ Date: _____