PRINCETON
INTEGRATED
HEALTHCARE

Intake Form

Patient Name_____ Date: _____ Email: _____
SS #/SIN_____ DOB_____ ☐ Male ☐Female Home phone_____Cell Phone _____
Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's Address _____City _____ State_____ Zip_____
Employer Name: _____
Spouse or Patient's Guardian name_____ Spouse's Employer_____
Whom may we thank for referring you? _____
Person to contact in case of an emergency_____ Phone_____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

Responsible Party
Name of The Person responsible for this account _____Relationship to Patient _____
Address _____Home Phone _____
E-Mail _____Cell Phone _____
Driver's License # _____ Date of Birth: _____
Is the person currently a patient at our office? □ Yes □ No
Do you have any Medical insurance? □ Yes □ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____
Address of Employer_____ State _____ Zip_____
Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **YOUR Princeton Integrated Healthcare** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(Patient signature)

X_____(SEAL)
(Signature of Guardian if applicable)

X_____
(Please print patient name)

Health History
Patient Name: _____DOB: _____Date:_____

Chief Complaint (CC): _____

History of Present illness (HPI):
Location: _____
(Where is the pain/problem? Side?)
Severity: _____
(How severe is the pain/problem on a scale of 0-10 with 10 being the most severe?)
Timing: _____
(Does the pain/problem occur at a specific time?)
Associated Signs/Symptoms _____
_____
(What other associated problems have you been having?)

Quality: _____
(Please describe your pain)
Duration: _____
(How long have you had this pain/ problem? When did it start?)
Context: _____
(Where were you at the onset of this pain/problem?)
Modifying Factors _____
(What makes the pain/problem worse or better?)

Have you had similar problem in the past? Yes/No If so, how was it treated?_____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain)

Measles	NO/YES	Scarlet Fever	NO/YES	Hernia	NO/YES
Anemia	NO/YES	Tuberculosis	NO/YES	Bronchitis	NO/YES
Back Trouble	NO/YES	Bleeding Tendency	NO/YES	Venereal Disease	NO/YES
Hepatitis	NO/YES	Diphtheria	NO/YES	Blood or Plasma	
Mumps	NO/YES	Diabetes	NO/YES	Transfusion	NO/YES
Bladder Infection	NO/YES	Asthma	NO/YES	Mitral Valve	
High Blood Pressure	NO/YES	Any Other Disease	NO/YES	Prolapses	NO/YES
Ulcer	NO/YES	Small pox	NO/YES	Stroke	NO/YES
Chicken Pox	NO/YES	Hives of Eczema	NO/YES	Cancer	NO/YES
Epilepsy	NO/YES	Pneumonia	NO/YES	If yes what Kind: _____	
Low Blood Pressure	NO/YES	Polio	NO/YES	In remission	NO/YES
Kidney Disease	NO/YES	AIDS & HIV	NO/YES	Other Diseases	NO/YES
Whooping Cough	NO/YES	Rheumatic Fever	NO/YES	Other _____	
Migraine Headaches	NO/YES	Glaucoma	NO/YES	_____	
Hemorrhoids	NO/YES	Infectious Mono	NO/YES	_____	
Thyroid Disease	NO/YES	Arthritis	NO/YES		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication List: (include nonprescription)

_____
_____
_____
_____

Allergies/Medication Allergies:

_____

_____

Primary Care Physician:_____

Are you taking any medications (prescription or over the counter) for acid indigestion? Yes/No
If yes what type: _____
Date of the last menstrual cycle: _____ Are you pregnant or do you think you might be pregnant? Yes/No
Are you breastfeeding? Yes/No

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure at home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

PATIENT NAME: _____ **DATE:**_____

Family Medical History

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review Of Systems

Please indicate which of the bellow you have experienced in the last 1-2 months

1-Never; 2- Rarely, 3-Occasionally, 4 – Frequently, 5- Constantly

Eyes/Ears/Nose/Throat/Respiratory

Blurred Vision	1 2 3 4 5
Double Vision	1 2 3 4 5
Earache	1 2 3 4 5
Recent Hearing loss	1 2 3 4 5
Ringing in Ears	1 2 3 4 5
Chronic Ear Infections	1 2 3 4 5
Sore Throat	1 2 3 4 5
Difficulty swallowing	1 2 3 4 5
Asthma	1 2 3 4 5
Apnea	1 2 3 4 5
Pneumonia	1 2 3 4 5
Coughing/Wheezing	1 2 3 4 5
Emphysema	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Osteoporosis	1 2 3 4 5
Arthritis	1 2 3 4 5
Scoliosis	1 2 3 4 5
Neck Pain	1 2 3 4 5
Low back Pain	1 2 3 4 5
TMJ Issues	1 2 3 4 5
Muscle Weakness	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/n shoulder Blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Dizziness	1 2 3 4 5
Anxiety	1 2 3 4 5
Depression	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling hands/feet	1 2 3 4 5
Pins and needles Hands/feet	1 2 3 4 5
Burning hands/feet	1 2 3 4 5
Brain/Head Injury	1 2 3 4 5
Memory Issues	1 2 3 4 5
Sleeping Issues	1 2 3 4 5
Loss of Smell/Taste	1 2 3 4 5
Carpal Tunnel	1 2 3 4 5

Gastrointestinal

Nausea/Vomiting	1 2 3 4 5
Abdominal Pain	1 2 3 4 5
Heartburn	1 2 3 4 5
Ulcer	1 2 3 4 5
Change Bowel Habits	1 2 3 4 5
Food Sensitivities	1 2 3 4 5
Diarrhea	1 2 3 4 5
Gallbladder Problems	1 2 3 4 5
Constipation	1 2 3 4 5
Blood in Stool	1 2 3 4 5

Endocrine

Diabetes	1 2 3 4 5
Hyperthyroidism	1 2 3 4 5
Hypothyroidism	1 2 3 4 5
Pancreatic Conditions	1 2 3 4 5

Genitourinary

Frequent Urination	1 2 3 4 5
Incontinence	1 2 3 4 5
Blood in urine	1 2 3 4 5

Derm/Hemo

Easy Bruising	1 2 3 4 5
Eczema	1 2 3 4 5
Skin Cancer	1 2 3 4 5

Cardiovascular

Palpitations	1 2 3 4 5
Dizziness	1 2 3 4 5
High Blood Pressure	1 2 3 4 5
High Cholesterol	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor/APN Date