Sensible Healthcare LLC
2700 Old Winter Garden Road
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Intake Form

Demographic Information

Name: _____ (LEGAL NAME) **Date**: _____ / _____ / _____
FIRST MIDDLE LAST

Date of Birth: _____ / _____ / _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Native Hawaiian/Other Pacific Islander

☐ Other, Specify: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Marital Status: _____ **Highest Level of Education:** _____ **Occupation:** _____

Patient Contact Information

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **What is the best time of Day to Contact You?** _____

Emergency Contact Information

☐ **None**

Primary Emergency Contact Name: _____ **Phone:** _____

Secondary Emergency Contact Name: _____ **Phone:** _____

Primary Care Physician Information

☐ **None**

Primary Care Physician or Office Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Office Number: _____ **Fax Number:** _____

Allergies ☐ None		
Food/Drug Allergy	**Start Date**	**Reaction**
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	

Medications (Prescription and/or Over the Counter) ☐ None				
Medication	**Current Dose**	**How Often**	**Start Date**	**FOR SITE USE ONLY:** **Indication**
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	
			_____/_____/_____	

Surgical History ☐ None		
Surgery	**Date**	**Reason for Surgery**
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	

Do you anticipate or expect surgery in the next year? ☐ Yes ☐ No
If yes, please specify surgery/reason: _____

Medical History ☐ None		
Diagnosis	**Start Date**	**Stop Date or Ongoing**
☐ Seasonal Allergies / Allergic Rhinitis	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Asthma	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ COPD	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Emphysema	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Sleep Apnea ☐ Use CPAP or BiPAP	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Heart Attack	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ High Blood Pressure	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ High Cholesterol / Lipids	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Coronary Artery Disease	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Congestive Heart Failure	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Peripheral Vascular Disease	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Acid Reflux / GERD	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Gastroparesis	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Irritable Bowel Syndrome	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Diabetes Mellitus; Type:	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Hypothyroidism (Underactive Thyroid)	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Gout	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ HIV / AIDS	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Cancer; Type:	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Fatty Liver Disease	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Hepatitis; Type:	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Chronic Kidney Disease	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Overactive Bladder	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Endometriosis	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Erectile Dysfunction	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Hypogonadism	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Benign Prostate Hypertrophy (BPH)	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Osteoarthritis; Location:	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Rheumatoid Arthritis	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Fibromyalgia	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Anxiety	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Depression	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Bipolar Disorder	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Schizophrenia	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Insomnia	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Migraine Headaches	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Seizure Disorder	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Stroke / TIA	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Alzheimer's Disease / Dementia	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Diabetic Peripheral Neuropathy	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Post-Herpetic Neuralgia (PHN)	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Psoriasis	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing
☐ Eczema	_____ / _____ / _____	_____ / _____ / _____ or ☐ Ongoing

Female Reproductive History ☐ NA, MALE

- Are you currently Pregnant, Lactating, or Breastfeeding? ☐ Yes ☐ No
- When was your last Menstrual Period? ________ / _________ / __________
- If you are no longer having Menstrual Periods, was this spontaneous or due to a procedure?
  - ☐ Spontaneous
  - ☐ Procedure
  - ☐ NA
- Check any reproductive procedures you have received:
  - ☐ Bilateral Tubal Ligation, Date: ________ / _________ / __________
  - ☐ Partial Hysterectomy, Date: ________ / _________ / __________
  - ☐ Complete Hysterectomy, Date: ________ / _________ / __________
  - ☐ Bilateral Oophorectomy, Date: ________ / _________ / __________
  - ☐ Uterine Ablation, Date: ________ / _________ / __________
  - ☐ Contraceptive Implant/IUD Placement, Date: ______ / _______ / _______ Type: __________________
  - ☐ None

Any Other Medical Conditions ☐ None		
Diagnosis	**Start Date**	**Stop Date or Ongoing**
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing
	_____ / _____ / ________	______ / ______ / ________ or ☐ Ongoing

Patient Signature : ____ **Date :** ______ / ______ / ________

Site Staff Signature : ____ **Date :** ______ / ______ / ________

Comment or NA ☐ : ____

____

DISCLAIMER : This is a prescreening document for Sensible Healthcare. It is **not** a source document.