RECOVIA
RESOLVE · RECLAIM · RECOVER

PATIENT INTAKE FORM

DATE: _____

1. PATIENT INFORMATION

Name: First	Last	
DOB:	Date of Injury:	
Address:		
Home Phone:	Cell Phone:	
SSN:	Email:	
Occupation:		
Emergency Contact:	Relation:	Phone:
Insurance Carrier:	Claim Number:	
Case Manager:	Case Manager Phone:	
Adjuster:	Referred By:	

2. PHARMACY INFORMATION

Pharmacy Name:	
Phone Number:	Fax Number (if available):
Address:	

3. ADDITIONAL INFORMATION

Who do you live with?
Other healthcare providers you are seeing (include primary care physician):

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4. MEDICAL HISTORY

a. If you are female are you currently pregnant? ☐Yes ☐ No

b. How would you describe your general state of health?
☐Excellent ☐Good ☐Fair ☐Poor

c. Please indicate any serious conditions, illnesses, injuries, brain injuries or trauma, and any hospitalizations; along with approximate dates:

Injury/Illness:	Date:
Injury/Illness:	Date:
Injury/Illness:	Date:
Injury/Illness:	Date:

d. Do you have any allergies (medicines, environmental, food, etc.)?

_____
_____
_____

e. Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____
_____
_____
_____

For Recovia use only: MED at intake_____

f. Please list past prescription medications:

_____
_____
_____
_____

g. Do you use any of the following? (check the box to indicate)
☐Aspirin ☐Laxatives ☐Antacids ☐Diet pills ☐Birth control pills ☐Implants ☐Injections

h. Alcohol Consumption: Do you drink alcohol? ☐Yes ☐ No

If yes, how frequently? (days/week): _____

i. Tobacco Use: Do you use tobacco? ☐Yes ☐ No

If yes, how frequently? _____

j. Caffeine: Do you drink caffeinated beverages? ☐Yes ☐ No

If yes, how frequently? _____

k. Recreational drugs: Do you use recreational drugs? ☐Yes ☐ No

If yes, what do you use and how often? _____

_____

l. Date of last medical check-up/physical/blood work:_____

m. Have you ever attempted suicide? ☐Yes ☐ No

n. Are you currently having thoughts of suicide? ☐Yes ☐ No

o. Have you ever been given a psychiatric diagnosis? ☐Yes ☐ No

If yes, describe your diagnosis: _____

_____

p. Hobbies:

_____

_____

q. Do you exercise regularly? ☐Yes ☐ No

If yes, what do you do for exercise and how often? _____

_____

_____

_____

5. FAMILY HISTORY

r. Please indicate if a close relative (parent, grandparent, aunt, sibling) has had any of the following: – please write relative(s) next to the item (i.e., “aunt – mother’s side”)

☐Allergies _____ ☐ Asthma _____

☐Heart Disease _____ ☐ High Blood Pressure _____

☐Cancer _____ ☐ Diabetes _____

☐Depression _____ ☐ Anxiety _____

☐Completed Suicide _____ ☐ Attempted Suicide _____

☐Alzheimer's Disease _____

s. How would you describe the emotional climate of your home?

_____
_____
_____

t. How stressful is your work, school, and/or other aspects of your life?

_____
_____
_____

u. How well do you handle these stressors?

_____
_____

v. Is there anything that you feel is important that has not been covered?

_____
_____