SOMA Face and Body

2578 McLeod Dr. North
Saginaw, MI 48604

Name: _____ DOB: _____

New Patient Intake Form

Patient Information

Last Name: _____First Name:_____DOB:_____

Home Phone:_____ Mobile Phone: _____

Email:_____Marital Status_____Spouse Name:_____

Emergency Contact: _____

Emergency Contact Phone:_____Relationship:_____

Occupation:_____Employer:_____

Primary Care Provider (PCP):_____PCP Phone: _____

Referring Provider:_____Referring Provider Phone: _____

Preferred Pharmacy:_____Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name:_____Specialty:_____

Doctor's Name:_____Specialty:_____

Doctor's Name:_____Specialty:_____

Doctor's Name:_____Specialty: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to SOMA Face and Body for services rendered. I authorize representatives of SOMA Face and Body release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the SOMA Face and Body Notice of Privacy Practices.
□ Received □ N/A (only if you received the notice from SOMA Face and Body previously)

I read and agree to all the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print) _____

*Patient or Legal Guardian Signature:*_____*Date:* _____

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Name: _____ DOB: _____

Reason(s) for today's visit: _____

_____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems ..... □Y □N
Arthritis ..... □Y □N
Bleeding/Clotting Disorder ..... □Y □N
Blood Pressure Disorder ..... □Y □N
Blood Transfusion ..... □Y □N
Bowel/Stomach Problems ..... □Y □N
Cancer..... □Y □N
Cholesterol Disorder ..... □Y □N
Diabetes ..... □Y □N
Eye Disorder (i.e. Glaucoma, cataract) ..... □Y □N

Women: Gynecological Issues.....□Y □N

Heart Disease/Disorder..... □Y □N
Lung Disorder..... □Y □N
Liver Disease ..... □Y □N
Neurological Disorder/Chronic Headaches ..... □Y □N
Psychiatric Disorder/Illness..... □Y □N
Pulmonary Embolism/DVT ..... □Y □N
Stroke..... □Y □N
Seizure or Epilepsy ..... □Y □N
Thyroid Disorder..... ..... □Y □N
Urinary/Kidney Disorder ..... □Y □N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	

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Name: _____ DOB: _____

Other:		□ Y □ N	

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked_____Packs/day _____

Do you use illicit substances? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: _____

Women: Any past pregnancies? □ Y □ N How many?_____How many deliveries? _____

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Name _____ DOB _____

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N If yes, please list all allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

Allergy	Reaction

Allergy	Reaction

Please list **ALL** of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

Please indicate ALL that you have experienced within the past 6 - 12 months:

Constitutional

Y □ N Fever	□ Y □ N	Fatigue	□ Y □ N Weight Gain (Lbs)	□ Other:
Y □ N Chills	□ Y □ N	Feeling Poorly	□ Y □ N Weight Loss (Lbs)	
	□ Y □ N	Sweats	□ Y □ N Unexp. Weight Change	
			□ Y □ N	Sleep Disturbances

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Name _____ DOB _____

Head, Eyes, Ears, Nose, and Throat

Y □ N Vision Problem	□ Y □ N	Red Eyes	□ Y □ N	Congestion	□ Y □ N	Hoarseness	
Y □ N Decreased Hearing	□ Y □ N	Eye Pain	□ Y □ N	Snoring	□ Y □ N	Ringing in Ears	
Y □ N Double Vision	□ Y □ N	Runny Nose	□ Y □ N	Dry Mouth	□ Y □ N	Vertigo	
Y □ N Light Sensitivity	□ Y □ N	Neck Stiffness	□ Y □ N	Flu-Like Symptoms	□ Y □ N	Earache	
Y □ N Itchy Eyes	□ Y □ N	Nosebleed	□ Y □ N	Sore Throat	□ Other:		

Cardiovascular

Y □ N Chest Pain	□ Y □ N	Cold Extremities	□ Y □ N	Irregular Heart Rhythm			
Y □ N Palpitations	□ Y □ N	Cold Hands or Feet	□ Other:				
Y □ N Leg Swelling	□ Y □ N	Leg Pain w Walking					

Respiratory

Y □ N Shortness of Breath	□ Y □ N	Wheezing	□ Y □ N	Coughing Up Blood			
Y □ N Cough	□ Y □ N	Shortness of Breath	□ Y □ N	Coughing Up Sputum			
Y □ N Rapid Breathing	□ Y □ N	Chest Congestion	□ Other:				

Gastrointestinal

Y □ N Abdominal Pain	□ Y □ N	Diarrhea	□ Y □ N	Change in Bowels	□ Y □ N	Heartburn	
Y □ N Blood in Stool	□ Y □ N	Black/Tarry Stools	□ Y □ N	Vomiting Blood	□ Other:		
Y □ N Vomiting	□ Y □ N	Decreased Appetite	□ Y □ N	Bowel Incontinence			
Y □ N Nausea	□ Y □ N	Yellow Skin	□ Y □ N	Rectal Pain			
Y □ N Constipation	□ Y □ N	Trouble Swallowing	□ Y □ N	Painful Swallowing			

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Name _____ DOB _____

Neurological

□ Y □ N Headache	□ Y □ N Unsteady	□ Y □ N Numbness	□ Y □ N Tremor
□ Y □ N Dizziness	Disorientation	□ Y □ N Tingling	□ Y □ N Memory Lapses
□ Y □ N Decreased Strength	□ Y □ N Confusion	□ Y □ N Seizures	□ Y □ N Memory Loss
□ Y □ N Poor Coordination	Burning Sensation	□ Y □ N Fainting (Syncope)	□ Other:

Musculoskeletal

□ Y □ N Joint Pain	□ Y □ N Limb Pain	□ Y □ N Muscle Pain	□ Other:
□ Y □ N Neck Pain	□ Y □ N Joint Swelling	□ Y □ N Muscle Weakness	
□ Y □ N Back Pain	□ Y □ N Muscle Cramps	□ Y □ N Leg Swelling	

Genitourinary

□ Y □ N Frequent Urination	□ Y □ N Pelvic Pain	□ Y □ N Painful Intercourse	□ Y □ N Heavy Bleeding
□ Y □ N Incontinence	□ Y □ N Nocturia	□ Y □ N Discharge- Vaginal	□ Other:
□ Y □ N Urinary Urgency	□ Y □ N Itching- Genital	□ Y □ N Vaginal Bleeding	
□ Y □ N Painful Urination	□ Y □ N Change in Libido	□ Y □ N Irreg. Monthly Cycles	

Integumentary

□ Y □ N Rash	□ Y □ N Skin Wound	□ Y □ N Unusual Growth	□ Y □ N Skin Cancer
□ Y □ N Dry Skin	□ Y □ N Change in A Mole	□ Y □ N Itching	□ Other:

Psychiatric

□ Y □ N Depression	□ Y □ N Anxiety	□Other:

Hematologic/Lymphatic

□ Y □ N Easy Bruising	□ Y □ N Easy Bleeding	□ Y □ N Swollen Lymph Nodes	□ Other:

Endocrine

□ Y □ N Excessive Thirst	□ Y □ N Heat Intolerance	□ Y □ N Changes- Skin
□ Y □ N Cold Intolerance	□ Y □ N Changes- Hair	□ Other:

OFFICE USE ONLY:

Date: _____

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Name _____ DOB _____

Provider/Staff Signature: _____