Dr. Mary Steiner
2700 Fait Ave, Baltimore, MD 21224

INTAKE FORM

Date:____________________________

Last Name:__________________________ First Name:_________________________

Birth Date:_______/_______/_______ Gender: Male____ Female____

Status: Married____ Single____ Children_____

Address:____

City:____________________________ State:______ Zip:_________________

Telephone: Home:__________________________Work:__________________________

Cell:_____________________________Other:_________________________

Email:____

Occupation:____

Employer:____

Emergency Contact:_________________________________ Phone:__________________
Relationship:_________________________________

Referred By:____

Insurance Carrier:____

Policy ID:____________________________________ Group #:______________________

Primary Account Holder:___________________________________Birthdate: ___/___/__
Relationship to Holder: Self____ Spouse____ Child____

Office Policy

Within this office, your health information is kept confidential at all times. Your information is used solely for treatment, to obtain payment, and for health care operations including administrative purposes and evaluation of the care that you receive.

Payment is expected at the time of service unless prior arrangements have been made. Please be advised that if you choose to use health insurance, benefits are not a guarantee of service or payment. YOU will be responsible for any balance unpaid by your insurance carrier.

Please sign below to acknowledge your understanding of this information.

Signature:____ Date:____/____/____

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Reason for visit:____
____
____

When did pain begin?____

How did pain begin?____

Describe the symptoms: (Circle all that apply)

*Sharp pain *Dull pain *Stabbing pain *Numbness *Tingling *Ache

*Other (describe):____

Describe the frequency/duration of symptoms: (Circle all that apply)

*All night *Morning *Afternoon *Evening *Daily *Weekly *Monthly

*Other (describe):____

Review of systems: Please circle <u>any</u> symptoms that apply to <u>you</u>.

Cardiovascular: Heart palpitations * High blood pressure * Chest pain * Calf pain * Other:________________

Respiratory: Trouble breathing * Asthma * Shortness of breath * Smoking History: (length of time)_________

Gastrointestinal: Digestive problems * Ulcers * Reflux (GIRD) * Nausea * Other:________________________

Genitourinary: Painful urination * Changes in urination color/frequency * Painful coitus * Other:____________

Neurological: Trouble concentrating * Numbness * Headaches * Tremors * Other:______________________

Psychiatric: Depression * Hallucinations * Schizophrenia * Memory loss * Other:________________________

Endocrine: Menstrual problems * Night sweats * Diabetes * Thyroid dysfunction * Other:________________

Hematological: Bruising easily * MRSA * Anemias * Swelling in legs * Other:___________________________

Allergic/Immunological: Seasonal allergies * Frequent infections * Other:_____________________________

Eyes/Ears/Nose/Throat: Vision trouble * Hearing dysfunction * Colds/flu * Swallowing difficulty * Other:____

Operations (list date and type):____

Review of family history: Using the "review of systems above" as a guide, please note any pertinent family history below:____
____

Social History: Please circle and describe all that apply to you:

Exercise: Frequency ____ per week/month * Weight training * Cardio * Sports:_________________________

Activities of Daily Living: Please describe all that are currently being affected by your condition:

Sleeping:____

Exercising:____

Job/Work:____

Driving:____

Family life:____

Hygiene (bathing, dressing, teeth):____

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Signature:____ **Date:** _____/_____/_____