whiteclover
WELLNESS & RESEARCH CENTER

460 Ashley Ridge Blvd, Ste 600 Shreveport, LA 71106 318.861-4226

NEW PATIENT INTAKE FORM Page 1 of 2

Date:__________________

Patient Name:____ DOB:__________________________

What brings you in today? ____

Primary Care Physician: ____ Referring Physician: __________________________________

How long have you had your current symptoms:____________________ Status: ❑ Improving ❑ Stable ❑ Worsening

Have you had labs or imaging for your current symptoms? ❑Yes ❑No When:____________ Where:_______________________

If so, what were the results? ____

Living Accomodations: ☐ Lives with Spouse ☐ Lives alone ☐ Lives with parent(s) ☐ Other ______________________

Tobacco: ☐ Do Not Smoke
☐Quit Smoking _______ ☐years ago ☐months ago
☐Smoke _____ packs ☐daily ☐weekly
☐Dip ________ times day

Alcohol:☐ I do not consume alcohol
☐ consume_____ drinks ☐daily ☐weekly

ALLERGIES: ____
____
____

Preferred Pharmacy:____

Medications: Please list all of your current medications (including viatmins/supplements):

Medication	Dose	Frequency	Taken For	Prescribed By

Date:________________ Patient Name:____ Chart #:_____________

MEDICAL & FAMILY HISTORY: Place a check mark (√) in the appropriate boxes to identify all illnesses/conditions in your **blood relatives** or yourself

Illness	Self	Father	Mother	Sibling	NONE
Cancer					
Heart Disease					
Diabetes					
Stroke/TIA					
High Blood Pressure					
Kidney/Renal Disease					
Liver Disease					
Alcohol/Drug Addiction					
Anxiety/Depression					
Tuberculosis					

Illness	Self	Father	Mother	Sibling	NONE
Migraines					
Coronary Artery Disease (CAD)					
Congestive Heart Failure (CHF)					
Anemia					
Arthritis					
Bleeding Disorder					
Osteoporosis					
Stroke (Cerebrovascular Disease)					
Other:________________________					
Other:_________________________					

Surgical History:____

____

____

Please indicate if you have the following symptoms:

Constitutional
- ❑yes ❑no Weight Loss
- ❑yes ❑no Weight Gain
- ❑yes ❑no Fever/Chills
- ❑yes ❑no Night Sweats
- ❑yes ❑no Hair Loss
- ❑yes ❑no Weakness

Eyes
- ❑yes ❑no Blurred or double vision
- ❑yes ❑no Painful or Dry Eyes
- ❑yes ❑no Disease or Cataracts
- ❑yes ❑no Infection or Injury
- ❑yes ❑no Blind Spots or Floaters

Ear/Nose/Mouth/Throat
- ❑yes ❑no Headaches
- ❑yes ❑no Sinus pain
- ❑yes ❑no Nose bleeds
- ❑yes ❑no Sore throat
- ❑yes ❑no Voice change
- ❑yes ❑no Ulcers of Mouth/Nose
- ❑yes ❑no Bleeding Gums
- ❑yes ❑no Dry Mouth
- ❑yes ❑no Earache/Ear Infection
- ❑yes ❑no Hearing Loss or Ringing

Cardiovascular
- ❑yes ❑no Chest Pain
- ❑yes ❑no Irregular Heartbeat
- ❑yes ❑no Swelling hands/feet
- ❑yes ❑no Varicose Veins
- ❑yes ❑no High Blood Pressure
- ❑yes ❑no Heart Disease

Respiratory
- ❑yes ❑no Wheezing
- ❑yes ❑no Chronic Cough
- ❑yes ❑no Shortness of Breath
- ❑yes ❑no Spitting up Blood
- ❑yes ❑no Sleep Apnea
- ❑yes ❑no Bronchitis
- ❑yes ❑no Pneumonia
- ❑yes ❑no Asthma
- ❑yes ❑no Tuberculosis

Gastrointestinal
- ❑yes ❑no Diarrhea
- ❑yes ❑no Constipation
- ❑yes ❑no Abdominal Pain
- ❑yes ❑no Indigestion/Heartburn
- ❑yes ❑no Blood in Stool
- ❑yes ❑no Nausea or vomiting

Genitourinary
- ❑yes ❑no Frequent Urination
- ❑yes ❑no Painful Urination
- ❑yes ❑no Blood in Urine

Endocrine
- ❑yes ❑no Heat Intolerance
- ❑yes ❑no Cold Intolerance
- ❑yes ❑no Diabetes
- ❑yes ❑no Thyroid Disease
- ❑yes ❑no Excessive Thirst
- ❑yes ❑no Excessive Urination
- ❑yes ❑no Tired/Sluggish

Skin/Breast
- ❑yes ❑no Rash or lesions
- ❑yes ❑no Itching
- ❑yes ❑no Skin color change
- ❑yes ❑no Breast Pain/Lumps
- ❑yes ❑no Breast Discharge

Neurologic
- ❑yes ❑no Frequent Headaches
- ❑yes ❑no Seizures or Tremors
- ❑yes ❑no Dizziness
- ❑yes ❑no Numbness/Tingling

Psychological
- ❑yes ❑no Depression
- ❑yes ❑no Anxiety/Nervousness
- ❑yes ❑no Memory Loss/Confusion
- ❑yes ❑no Insomnia

Hematologic/Lymphatic
- ❑yes ❑no Swollen Gland
- ❑yes ❑no Enlarged Lymph Nodes
- ❑yes ❑no Anemia
- ❑yes ❑no Phlebitis or clots in legs
- ❑yes ❑no Anemia
- ❑yes ❑no Tendency to bleed/bruise
- ❑yes ❑no Slow to heal after cuts

Musculoskeletal
- ❑yes ❑no Joint Pain
- ❑yes ❑no Joint Swelling or Stiffness
- ❑yes ❑no Back Pain
- ❑yes ❑no Neck Pain
- ❑yes ❑no Muscle or Joint

Weakness
- ❑yes ❑no Limitation of Motion
- ❑yes ❑no Muscle Pain or Cramps
- ❑yes ❑no Cold Extremities
- ❑yes ❑no Pain while at rest
- ❑yes ❑no Arthritis

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NEW PATIENT EXAM

Date:_________________ **Patient Name:**____ **Chart #:**_____________

BP ___________; Height _____ft ____in; O_2 _____%; Pulse _______; RR _______; Temp _____; Weight_____(lb); VRS ____/10

Gen Appearance: (□ well-appearing □ ill-appearing □ debilitated) (□ no acute distress □ mild □ moderate □ severe distress)

HEENT: □Normal □Not Tested □ Change ____
NECK: □Normal □Not Tested □ Change ____
LUNGS: □Normal □Not Tested □ Change ____
HEART: □Normal □Not Tested □ Change ____
ABD: □Normal □Not Tested □ Change ____
PERIPH: □Normal □Not Tested □ Change ____
SKIN: □Normal □Not Tested □ Change ____
Upper extremities ___R ___L; Lower extremities ___R ___L
Mental Status □Normal □Not Tested □ Change ____
Cranial Nerves: □Normal □Not Tested □ Change ____
Motor Sys: □Normal □Not Tested □ Change ____
Coordination: □Normal □Not Tested □ Change ____
Manual Muscle: □Normal □Not Tested □ Change ____
Sensory: □Normal □Not Tested □ Change ____
Gait/Station: □Normal □Not Tested □ Change ____
Reflexes: □Normal □Not Tested □ Change ____

ASSESSMENT: ____

____

____

____

Education: □ Education provided _____ minutes. □ Smoking Cessation Counseling Provided

PLAN: □ UVLrx Therapy: # Treatments Recommended: __________

□ Labwork____

□ Other: ____

Follow Up: □ _____ (weeks / months) □ Call for appointment when needed

□ Follow-up with PCP____

Additional Notes:

____

____

____

____

____
Bethany C. Crosby, P.A.-C