Ivy Collaborative Healthcare
New Patient Intake Form

List any recent family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)? ____

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Medical History: ☐None ☐ Arthritis ☐ Asthma ☐ Bleeding Disorder
☐ Blood Clots (or DVT) ☐ Coronary Artery Disease ☐ Diabetes ☐ Heart Murmur
☐ Structural Heart Abnormality ☐ High Cholesterol ☐ High Blood Pressure ☐ Kidney Disease
☐ Thyroid Disease ☐ Head trauma ☐ Loss of Consciousness ☐ Concussion
☐ Seizures ☐ Other ____

List ALL Current Psychiatric and Non-Psychiatric Medications (including over the counter, herbal medications and vitamins)

Name of Medication	How many milligrams (mg)?	When is it taken? (am, pm, twice a day, etc.)	Reason for medicine?
1			
2			
3			
4			
5			

Allergies: include anything you are allergic to (medications, food, bee stings, etc) and how each affects you: ☐ None

Allergy | Reaction

______________________________ ______________________________

______________________________ ______________________________

Preferred Pharmacy: ______________________________ **Location**:______________________________

Previous Psychiatric Diagnoses: ____

Previous Psychiatric Medication trials:

Medication	Dose	Frequency	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s)
1				
2				
3				
4				
5				

Psychiatric Hospitalizations and/or Residential Treatment:

Dates	Hospital	Reason

Social History:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

1. Name____ Relationship to the patient:________________________
2. Name____ Relationship to the patient:________________________
3. Name____ Relationship to the patient:________________________
4. Name____ Relationship to the patient:________________________
5. Name____ Relationship to the patient:________________________

Education:

- Adult (List highest grade completed): ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate
- Child/Adolescent: (List current grade and school) ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Occupation: Currently Working? ☐Yes, describe: ____ ☐ No ☐ On Disability ☐ Retired

Hobbies: ____

Smoking History: ☐ Never smoked ☐ Former Smoker ☐ Current Smoker ___________ packs/cigars per day

Alcohol: Do you drink alcohol? ☐ No ☐ Yes. How often? ☐ Occasionally ☐<3 times a week ☐ >3 times a week How many drinks per week? ____

Guns in the home?: ☐ No ☐ Yes Is gun safety being practiced?

REVIEW OF SYSTEMS: Please check(✓) all **CURRENT** positive findings

Constitutional	Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes	Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT	Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular	Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory	Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal	Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary	Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTI's ☐
Skin	Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal	Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐
Psychiatric	Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Endocrine	Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excessive sweating ☐
Neurological	Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Heme/Lymphatic	Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immun	Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Signature Acknowledgement

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal or the practice's website to review and print your documents or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

- ✓ **HIPPA Privacy Notice**
- ✓ **Financial Policies**
- ✓ **Notice of Privacy Practices**

Patient Signature: ____ **Date**: _________________

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Reviewed by Physician/APRN: ____ **Date**:__________________