Clinical Nurse Consultants

New Patient Intake Form and Consent to Treat

Patient Information:

1. **First Name:** ____________________________ **Last Name:**________________________
2. **Date of Birth:** ___________________________SSN#_____________________________
3. **Gender:** □ Male □ Female □ Other □ Prefer not to say
4. **Race:** □ Caucasian □ African American □Asian □ Indian □ Other__________________
   □ Prefer not to say
5. **Ethnicity**: □ Hispanic □ Non-Hispanic □ Prefer not to say
6. **Marital Status:** □ Single □ Married □ Divorced □ Widowed
7. **Phone Number:** ____________________ **Email Address:** _______________________
8. **Address:** __________________________________
   City: ______________________ State:_________ Zip code:_________________
9. **Emergency Contact Name:** _______________________ Relationship:_____________
   Address: __________________________________
   City: _____________ State:_____ Zip code:_____________
10. **Emergency Contact Phone Number:** ___________________

Insurance Information:

11. **Primary Insurance Provider:** _________________ **Insurance Policy #:**____________
12. **Secondary Insurance Provider:** ________________ **Secondary Policy #:** __________
13. **Policy Holder Name (if not the patient):** ______________
14. **Policy Holder Date of Birth:** ________________________

Primary Care Physician Information:

15. **Previous PCP Name:** ____________________ **PCP Phone #:** _________________

Medical History:

16. **Do you have any chronic conditions?** □ Yes □ No If yes, please complete next page
17. **Allergies:** □ Yes □ No If yes, please list: _______________________________________
18. **Have you had any surgeries?** □ Yes □ No
    If yes, please list: ______________________________________
19. **Family History (e.g., heart disease, diabetes, cancer, etc.):**
    ____
    ____
20. **Do you smoke?** □ Yes □ No If yes, how many per day?____________________________
21. **Do you drink alcohol?** □ Yes □ No If yes, how often?____________________________
22. **Do you use recreational drugs?** □ Yes □ No If yes, please specify: __________________

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants

Clinical Nurse Consultants

Consent for Treatment:

I consent to the medical treatment and diagnostic procedures that may be provided by the physician or nurse practitioner.

□ Yes □ No Patient Signature: ____________________________Date: ________________

Notice of Privacy Practices: By signing this form, you acknowledge that you have received or been offered the Notice of Privacy Practices as required by law.

For Office Use Only:

- **Patient ID Number: ________________________**
- **Entered into System by: ________________________**
- **Date: ________________________**

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants

Clinical Nurse Consultants

Medical History Intake

Name:______________________
DOB:_________________

Cardiovascular

☐ Hypertension
☐ Coronary artery disease
☐ Congestive heart failure
☐ Atrial fibrillation
☐ Hyperlipidemia
☐ Peripheral vascular disease
☐ Orthostatic hypotension
☐ Other:
____

Respiratory

☐ COPD
☐ Asthma
☐ Chronic bronchitis
☐ Emphysema
☐ Shortness of breath
☐ Oxygen use
☐ Other:
____

Neurologic / Cognitive

☐ Dementia
☐ Mild cognitive impairment
☐ Parkinson's disease
☐ Stroke/TIA
☐ Neuropathy
☐ Seizure disorders
☐ Other:
____

Psychiatric / Behavioral Health

☐ Depression
☐ Anxiety
☐ Insomnia
☐ Behavioral disturbances
☐ Mood disorders
☐ Psychosis (stable)
☐ Other:
____

Endocrine / Metabolic

☐ Type 2 diabetes
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Osteoporosis
☐ Vitamin D deficiency
☐ Obesity
☐ Other:
____

Musculoskeletal

☐ Osteoarthritis
☐ Osteoporosis
☐ Chronic joint pain
☐ Back pain
☐ Gout
☐ History of falls
☐ Mobility impairment
☐ Other:
____

Renal / Genitourinary

☐ Chronic kidney disease
☐ UTIs
☐ Urinary incontinence
☐ BPH
☐ Overactive bladder
☐ Other:
____

Gastrointestinal

☐ GERD
☐ Constipation
☐ Diarrhea
☐ Diverticulosis
☐ Nausea/vomiting
☐ Poor appetite/weight loss
☐ Other:
____

Dermatologic / Wound Care

☐ Pressure injuries
☐ Skin tears
☐ Rashes/dermatitis
☐ Cellulitis
☐ Chronic wounds
☐ Fungal infections
☐ Other:
____

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants

Clinical Nurse Consultants

First Name:______________________ **Last name:**__________________ **DOB:**___________

Address:___________________________ **City:**_____________ **State:**_____ **Zipcode:**_______

Pharmacy Name:_________________________ **Telephone Number:**__________________

Current Medication List

Medication	**Dose**	**Frequency**	**Refill Needed**
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No
			▯ Yes ▯ No

Patient/responsible party signature: ___________________________ **Date:**_____________

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants