INTAKE form
for prospective patients

For Office Use Only:

Appt _____ *Dr. Arthur / Dr. Burt*
DATE/TIME

Follow-up date/time _____

Date of Intake: _____

PATIENT INFORMATION

Male/Female (circle) Age: _____ Birth date: _____ Insurance: _____

We are not contracted with insurance companies, but will submit claims for you for possible reimbursement.

Name: _____ Hm Ph: _____ (Ok leave msg?)
Last First

Address: _____ Cell: _____ (Ok leave msg?)

_____ Work: _____ (Ok leave msg?)

Occupation: _____ Email: _____

In order of importance, what are your concerns/reasons for seeing Dr. Berkson?

1. _____ Date of Onset: _____
2. _____ Date of Onset: _____
3. _____ Date of Onset: _____
4. _____ Date of Onset: _____

	CIRCLE ONE			CIRCLE ONE	
Do you have an appetite?	**Y**	**N**	Can you swallow pills?	**Y**	**N**
Are you on disability?	**Y**	**N**	Are you lactose intolerant?	**Y**	**N**
Are you under psychiatric care?	**Y**	**N**	Are you on Narcotic pain meds?	**Y**	**N**
Do you have a history of sore throats, environmental/chemical exposures ?				**Y**	**N**

Please list prescribed medications:

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Please list any Allergies to medication:

How were you referred to us?

If you are not local (in Las Cruces)

	CIRCLE ONE			CIRCLE ONE	
Are you stable to travel?	**Y**	**N**	Can you stay 5 day min., possibly every 3 months?	**Y**	**N**

Complete this section If concerns involve the liver

	CIRCLE ONE		ANSWER IF YES
Any ascities (fluid buildup in the abdomen)?	**Y**	**N**	What size belly, like a pregnancy ____ month.
Belly being tapped?	**Y**	**N**	How often? _____
Had Interferon/Ribaviron/Peg?	**Y**	**N**	When? _____

	CIRCLE ONE		
Alcohol Use?	**Y**	**N**	Frequency: _____
Drug Use?	**Y**	**N**	Frequency: _____
Support Group?	**Y**	**N**	

Lab Values: Albumin: _____ Protime/Prothrombin: _____ Platelet: _____

Date of Labs: _____

Complete this section if concerns involve cancer.

(Only if local. Out of town cancer patients may come for lifestyle/supplement recommendations only).

Diagnosis**:**

	CIRCLE ONE	
Have you had a G6PD enzyme test?	**Y**	**N**
If yes, result _____		
Any ascities (fluid buildup in the abdomen)?	**Y**	**N**
If yes, what size belly, like a pregnancy _____ months.		
Belly being tapped?	**Y**	**N**
If yes, how often? _____		

Additional Comments

Attach additional pages if necessary, 8 page limit.