9015 Adams Ln
Suite C
Temple, TX 76502
(254) 307-2896

CTXO
CENTRAL TEXAS ORTHOBIOLOGICS

Current Date: _____/_____/_____
M D Y

Patient Intake Form

Name:_____
First Middle Last

Birthdate: _____/_____/____ Age: _____ Sex:_____
M D Y

Email: _____ May we email you reminders: Yes No

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Current Occupation: _____

Are you enrolled in Medicare: Yes No Preferred Pharmacy: _____

Family Physician Name and Clinic Name: _____

What do you want to accomplish at today's visit?

What body part(s) are you having issues with?

Is this a new issue? When did it first start? Was there an injury?

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What makes your issue feel worse? What makes it feel better?

What treatments have you tried? Did they help? Where were you treated?

Please list all medical conditions:

Please list all medications and supplements you currently take:

Please list all prior surgeries:

Do you currently or have you ever had cancer of any kind?

Do you use any nicotine products? Do you consume alcohol? Do you use any drugs?

Is there any other information that your provider should be aware of?