Patient Medical History Intake

Please complete this form as thoroughly as possible. Your attorney may help fill in gaps.

PRIVACY & HIPAA NOTICE

The information you provide on this form is protected under the Health Insurance Portability and Accountability Act (HIPAA). It will be used solely by Anchor Clinical Consulting, PLLC for the purpose of legal nurse consulting services related to your case. Your information will not be shared with any third party without your written authorization, except as required by law. You have the right to revoke this authorization in writing at any time.

SECTION 1 — PATIENT DEMOGRAPHICS

Full Legal Name _____

Date of Birth _____ **Preferred Name / Goes By** _____

Home Address _____

City _____ **State / ZIP** _____

Primary Phone _____ **Email Address** _____

Preferred Contact Method _____ **Best Time to Reach You** _____

Emergency Contact

Name _____ **Relationship** _____

Phone Number _____

SECTION 2 — CASE CONTEXT

Attorney / Law Firm Name _____

Case / Matter Name _____ **Date of Incident or Injury** _____

Brief description of why you are seeking legal help (1–2 sentences) _____

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SECTION 3 — MEDICAL HISTORY

Please check all conditions you have been diagnosed with, past or present.

- ☐ Hypertension
- ☐ Heart Attack (MI)
- ☐ Asthma / COPD
- ☐ Liver Disease
- ☐ Depression
- ☐ Schizophrenia / Psychosis
- ☐ Seizure Disorder / Epilepsy
- ☐ Arthritis / Joint Disease
- ☐ Diabetes (Type 1 or 2)
- ☐ Stroke / TIA
- ☐ Cancer (specify below)
- ☐ Thyroid Disorder
- ☐ Anxiety
- ☐ PTSD
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Heart Disease / CAD
- ☐ Atrial Fibrillation
- ☐ Kidney Disease
- ☐ HIV / AIDS
- ☐ Bipolar Disorder
- ☐ Substance Use Disorder
- ☐ Autoimmune Disease
- ☐ Chronic Pain

Other conditions not listed above _____

Surgeries & Hospitalizations

DATE / YEAR	PROCEDURE / REASON	HOSPITAL / FACILITY	OUTCOME

Allergies

ALLERGEN (medication, food, environmental)	REACTION / SEVERITY	YEAR IDENTIFIED

SECTION 4 — FAMILY MEDICAL HISTORY

List significant medical conditions in immediate family members (parents, siblings, children).

RELATION	CONDITION / DIAGNOSIS	AGE AT DIAGNOSIS	LIVING? (Y/N)	IF DECEASED, CAUSE

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SECTION 5 — CURRENT MEDICATIONS

List ALL medications, vitamins, supplements, and over-the-counter drugs you currently take.

MEDICATION NAME	DOSE / STRENGTH	FREQUENCY	PRESCRIBING PROVIDER	START DATE	REASON

Past Medications (relevant to your case or injury)

MEDICATION NAME	DOSE / STRENGTH	FREQUENCY	PRESCRIBING PROVIDER	START DATE	REASON

SECTION 6 — PRIOR PROVIDERS & FACILITIES

Include all doctors, specialists, hospitals, clinics, and therapists related to your case.

PROVIDER NAME / FACILITY	TYPE / SPECIALTY	CITY, STATE	DATES SEEN	REASON FOR VISIT

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SECTION 7 — MEDICAL TIMELINE

List key medical events in chronological order — diagnoses, procedures, ER visits, hospitalizations, changes in condition, or anything else that is important to understanding your medical history. Your attorney may help you fill in dates or details they are aware of.

DATE	EVENT / DESCRIPTION	PROVIDER / FACILITY	SIGNIFICANCE TO CASE

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SECTION 8 — CURRENT COMPLAINT & YOUR STORY

In your own words, describe what happened and how it has affected your life. There are no wrong answers — be as detailed as you can. Continue on the back or attach additional pages if needed.

What happened? (Describe the incident, injury, or medical event in your own words)

How has this affected your daily life, work, and wellbeing?

What symptoms are you experiencing right now?

Current pain level (circle or note): 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Is there anything else you want Nicole to know before reviewing your case?

Use this space freely — no detail is too small.

SECTION 9 — AUTHORIZATION & SIGNATURE

By signing below, I authorize Anchor Clinical Consulting, PLLC to review my protected health information (PHI) solely for the purpose of legal nurse consulting services in connection with my legal matter. I understand that my information will be kept confidential and will not be disclosed to any third party without my written consent, except as required by law. I confirm that the information provided in this form is accurate and complete to the best of my knowledge.

Patient Signature

Date

Printed Name

Relationship to Patient (if not patient)

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