MARVIX AI

PATIENT INTAKE FORM

CLINICAL INTAKE TEMPLATE

Questions? Visit us at www.marvix.ai

1 Patient Information

1a DEMOGRAPHICS

Full name: _____ MRN / Patient ID: _____

Date of birth: _____ Date of intake: _____

Age: _____ Preferred language: _____

Sex: _____ Interpreter needed: _____

1b CONTACT INFORMATION

Phone (primary): _____ Street address: _____

Phone (secondary): _____ City / State / ZIP: _____

Email address: _____ Preferred contact method: _____

1c EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____ Alternative phone: _____

1d INSURANCE INFORMATION

Primary insurance: _____ Secondary insurance: _____

Member ID: _____ Member ID (secondary): _____

Group number: _____ Co-pay / Deductible: _____

Policy holder name: _____ Referring provider: _____

2 Chief Complaint

2 PRIMARY REASON FOR SEEKING CARE

Primary complaint (patient's words): _____

Duration of current concern: _____

Urgency / acuity: _____

3 History of Present Illness

3a ONSET & DURATION

When did symptoms begin: _____ Course (improving / worsening / stable): _____

Onset (sudden / gradual): _____ Frequency / pattern: _____

3b SEVERITY & PROGRESSION

Severity (0–10 scale): _____

Progression since onset: _____

Aggravating factors: _____

Alleviating factors: _____

3c ASSOCIATED SYMPTOMS

List any other symptoms occurring alongside the primary complaint — e.g., fever, fatigue, nausea, pain, neurological changes, cardiorespiratory symptoms...

3d PRIOR EVALUATIONS & TREATMENTS

Previously seen by: _____

Prior diagnoses (if any): _____

Describe any prior evaluations, lab work, imaging, or treatments already tried — include response and outcomes...

4 Past Medical History

4a CHRONIC CONDITIONS

List all chronic or ongoing medical conditions with approximate year of diagnosis — e.g., hypertension (2018), Type 2 diabetes (2020), asthma (childhood)...

4b PRIOR HOSPITALIZATIONS

List hospitalizations with reason and approximate date — e.g., pneumonia (2022), chest pain workup (2019)...

4c SURGICAL HISTORY

List all prior surgeries or procedures with approximate dates — e.g., appendectomy (2015), cholecystectomy (2021), knee arthroscopy (2017)...

5 Medications

5 CURRENT MEDICATIONS

MEDICATION NAME	DOSE	FREQUENCY	PRESCRIBING PROVIDER

OTC / SUPPLEMENTS / VITAMINS

List any over-the-counter medications, supplements, vitamins, or herbal remedies...

6 Allergies

6 KNOWN ALLERGIES & REACTIONS

ALLERGEN (DRUG / FOOD / ENVIRONMENTAL)	TYPE	REACTION / SEVERITY

Contrast / latex allergy: _____

NKDA (No Known Drug Allergies): _____

7 Family History

7 HEREDITARY & FAMILIAL CONDITIONS

RELATION	CONDITION(S)	AGE OF ONSET / NOTES
e.g., Mother		
e.g., Father		
e.g., Sibling		
e.g., Maternal grandmother		
e.g., Paternal grandfather		

Family history of cancer: _____

Family history of cardiac disease: _____

Family history of mental illness: _____

8 Social History

8a OCCUPATION & LIVING SITUATION

Occupation: _____

Employment status: _____

Work environment: _____

Living situation: _____

Lives with: _____

Support system: _____

8b SUBSTANCE USE

Tobacco use: _____

Pack-year history: _____

Alcohol use: _____

Drinks per week: _____

Recreational drug use: _____

Substance(s) used: _____

Caffeine intake: _____

Exercise habits: _____

8c ADDITIONAL SOCIAL CONTEXT

Marital / relationship status: _____

Number of children / dependants: _____

Highest education level: _____

Diet / nutritional patterns: _____

Stress level (0–10): _____

Sleep (hours/night, quality): _____

9 Review of Systems

9 BRIEF SYSTEM-BASED SYMPTOM SCREENING

Document positive and pertinent negative findings. Use the field to record specific symptoms, or note "Negative" if no symptoms in that system.

Constitutional: _____

Cardiovascular: _____

Gastrointestinal: _____

Musculoskeletal: _____

Dermatologic: _____

Endocrine: _____

Immunologic / Allergic: _____

HEENT: _____

Respiratory: _____

Genitourinary: _____

Neurological: _____

Psychiatric: _____

Hematologic / Lymphatic: _____

Reproductive: _____

A Initial Assessment

10 PRELIMINARY CLINICAL IMPRESSION

Document the clinician's initial clinical impression based on intake information — working diagnoses, differentials, or areas of clinical concern...

11 RISK FACTORS & RED FLAGS

Check all that apply and document relevant detail in the field below.

- ☐ Suicidal / self-harm ideation
- ☐ Acute cardiac symptoms
- ☐ Neurological deficit
- ☐ Unintentional weight loss
- ☐ New-onset severe headache
- ☐ Fever of unknown origin
- ☐ Respiratory distress
- ☐ Immunocompromised state
- ☐ History of malignancy
- ☐ Recent trauma / injury
- ☐ Substance use disorder
- ☐ Domestic violence / safety concern

Document specific risk factor details, relevant clinical context, or additional red flags identified during intake...

P Plan

12 DIAGNOSTIC WORKUP

List labs, imaging, or other diagnostic studies to be ordered — e.g., CBC, CMP, HbA1c, ECG, chest X-ray, MRI brain; include clinical indication for each...

13 REFERRALS

SPECIALTY / PROVIDER	REASON FOR REFERRAL	URGENCY

14 INITIAL MANAGEMENT STEPS

Document immediate management decisions — medications initiated, lifestyle recommendations, safety planning, patient education, urgent interventions...

15 FOLLOW-UP

Return appointment: _____

Return earlier if: _____

Patient instructions: _____

CLINICIAN SIGNATURE

Clinician name: _____ **Date & Time:** _____

Credentials / NPI: _____ **Facility / Clinic:** _____

Signature: _____ **Visit type:** _____