PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

Patient Intake Form

Hope Healtcare Services mission – To worship God by meeting the needs of the underserved in our community in order to build bridges of faith in Jesus Christ.

PATIENT DEMOGRAPHICS					
			DATE		
NAME					
ADDRESS	STREET		APT NO.		
CITY	STATE	ZIP CODE	EMAIL		
TELEPHONE		CELL #		ALT. PHONE	
DATE OF BIRTH	MM-DD-YYYY		SOC. SECURITY NUMBER		
GENDER	□ MALE □ FEMALE		RELIGIOUS PREFERENCE		
EMERGENCY CONTACT			EMERGENCY PHONE #		
RELATIONSHIP TO PATIENT					

HOUSING	MARITAL STATUS	MILITARY STATUS	EMPLOYMENT STATUS	ETHNICITY & RACE	TRANSPORTATION	COUNTY	HIGHEST EDUCATION COMPLETED
□RENT □OWN □PUBLIC/SUBSIDIZED □HOMELESS □SHELTER □OTHER	□SINGLE □MARRIED □SEPARATED □DIVORCED □WIDOWED	□ACTIVE □VETERAN □NONE	□FULL TIME □PART TIME □TEMP. □UNEMPLOYED □DISABLED □RETIRED □FULL TIME STUDENT □PART TIME STUDENT	**ETHNICITY-** □HISPANIC OR LATINO □NON-HISPANIC OR LATINO **RACE-** □BLACK/AFRICAN-AMERICAN □ WHITE /CAUCASIAN □ ASIAN □ OTHER _____	□OWN CAR □OTHER CAR □PUBLIC □FOOT □NONE	□HENDRICKS □MORGAN □BOONE □PUTNAM □MARION □MONTGOMERY □OTHER _____	□K-8 □9-12 □HS/GED □SOME COLLEGE

INSURANCE INFORMATION		LIST CURRENT HEALTHCARE PROVIDERS			
□MEDICAID	□PRIVATE/OTHER _____	DR. NAME	PHONE #	SERVICE	STATUS
□MEDICARE A/B	□CATASTROPHIC	DR. E.X. AMPLE	999-999-9999	CARDIOLOGIST	X ACTIVE □INACTIVE
□VETERAN AFFAIRS	□HEALTH SAVINGS PLAN				□ ACTIVE □INACTIVE
	□NONE				□ ACTIVE □INACTIVE
					□ ACTIVE □INACTIVE
					□ ACTIVE □INACTIVE
					□ ACTIVE □INACTIVE

AUTHORIZED PERSON(S) TO HEAR MESSAGES LEFT BY HHS		VOICE MESSAGE OK
1	SELF	□
2		□
3		□
REFERRED TO HHS BY		

PRAYER REQUEST:_____

_____

_____

_____

SPIRITUAL NEEDS INVENTORY			
DO YOU HAVE A CHURCH HOME?	□ YES □ NO	WHERE?	
I WOULD LIKE TO KNOW MORE ABOUT HAVING A RELATIONSHIP WITH JESUS?		□ YES □ NO	
I WOULD LIKE TO BE CONTACTED ABOUT A SPIRITUAL ISSUE?		□ YES □ NO	

Hope Healthcare Services			
Name		Date	

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:_____

Other concerns: _____

_____

ALLERGIES	List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you
Allergy	*Reaction*
1.	
2.	
3.	
4.	
5.	

MEDICATIONS	Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	
DRUG NAME	STRENGTH	FREQUENCY TAKE
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
Preferred Pharmacy		Phone

Immunizations current		Yes		No		Unknown

PAST SURGICAL HISTORY			
SURGERY	REASON	YEAR	HOSPITAL
1			
2			
3			
4			

EMERGENCY ROOM		
VISIT/REASON	DATE/YEAR	HOSPITAL
1		
2		
3		
4		

PAST MEDICAL HISTORY	Please check all that apply				
	Anxiety Disorder		Diverticulitis		Kidney Disease
	Arthritis		Fibromyalgia		Kidney Stones
	Asthma		Gout		Leg/Foot Ulcers
	Bleeding Disorder		Has Pacemaker		Liver Disease
	Blood Clots (or DVT)		Heart Attack		Osteoporosis
	Cancer		Heart Murmur		Polio
	Coronary Artery Disease		Hiatal Hernia or Reflux Disease		Pulmonary Embolism
	Claustrophobic		HIV or AIDS		Reflux or Ulcers
	Diabetes - Insulin		High Cholesterol		Stroke
	Diabetes – Non-Insulin		High Blood Pressure		Tuberculosis
	Dialysis		Overactive Thyroid		Other

FAMILY HEALTH HISTORY				
RELATION	ALIVE?		AGE	SIGNIFICANT HEALTH PROBLEM
Grandmother (maternal)	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Genetic disease _Heart disease _Hypertension _Osteoporosis _Stroke
Grandfather (maternal)	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Grandmother (paternal)	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Grandfather (paternal)	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Father	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Mother	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Brother/Sister	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Brother/Sister	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease
Other:_____	Y	N		_Alcoholism _Arthritis _Depression _Cancer _Diabetes _Heart disease _Hypertension _Osteoporosis _Stroke _Genetic disease

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ _Abnormal
Last Mammogram Date _____ _Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
_Cesarean sections If yes, then number: _____
_Bleeding between periods
_Heavy periods
_Extreme menstrual pain

_Vaginal itching, burning, or discharge
_Wake in the night to go to the bathroom
_Hot flashes
_Breast lump or nipple discharge
_Painful intercourse
_Sexually active
Current sexual partner is _Female _Male
Do you use condoms? _Yes _No
Other Birth control method used:_____
_Interested in being screened for STD'

SOCIAL HISTORY

Occupation
_____

Education _Less than 8thgrade
_High school _2 year college
_4 year college _Post graduate

Marital Status _Married _Single
_Divorced _Separated _Widowed
_Domestic partner

Exercise Level _None (No exercise)
_Occasional exercise
_Moderate exercise
_High level exercise

Caffeine _None _Occasional
_Moderate _Heavy
# of cups/cans per day? _____

Alcohol Do you drink alcohol?
_Yes _No
If so, how often?
_Occasionally _< 3 times a week
_> 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
_Yes -No
If not currently, did you ever use tobacco? _Yes _No
_Cigarettes - _____pks./day
_Chew - _____/day
-Cigars - _____/day
_# of years_____
Or year quit _____

Drugs Do you currently use recreational or street drugs? _Yes _No
If yes, list:
_____
_____

Please add any other information about your health that you would like your provider to know here:
_____
_____
_____
_____

Certification and Authorization

I attest that all information provided for patient intake and medical history is complete, true and accurate.

Consent for Treatment

By signing this consent, I am agreeing to the receipt of medical and/or dental treatment by Hope Healthcare Services. I agree to have the designated person(s) review health information as needed for treatment. I am agreeing to keeping all set appointments or informing the office of necessary cancellations per the clinic policy.

_____ _____
Patient, Guardian, or Caregiver Signature Date

We at Hope Healthcare Services enjoy the mission we fulfill to our patients in west central Indiana. We are always looking to partner with local hospitals and facilities to better serve you, the patient. If you could please fill out a quick anonymous survey answering a few simple questions this would help in our mission to serve you. Thank you!

What facility (or person) referred you to our services?_____

On what date were you referred here?_____

How many times have you visited that facility prior to coming to our clinic?_____

What was your main motivation in seeking services through our clinic?_____

Were you denied services elsewhere?_____ If so, explain:

_____

Thank you again for your time. Please note that this information will be kept completely anonymous.