HARBOR CARE HEALTH AND WELLNESS CENTER Patient Intake Form

Please print clearly. If you need help filling out this form, please let us know.					
Full Name:				**Today's Date:**	
Email:				**Date of Birth:**	
Contact Phone:		Cell	Other	**Social Security #:**	
Mailing Address Actual Address					

Are you?	Male	Female	Transgender	Single	Married	Other
	Employed-Occupation:			Unemployed	Disabled	Retired
	Employer Name:			Employer Address:		

Do you have Health Insurance? Yes No

If yes, circle type: Medicare Medicaid Private

Insurance ID#

Please provide your card to the front desk staff to make a copy

How did you hear about us?

Where did you last receive health-related services?		
Emergency Room	**Doctor's Office**	**Other**
So. NH Hospital	Nashua Area Health Center	Nashua Health Department
St. Joseph's Hospital	Dartmouth Hitchcock	Jail/Prison
Other Hospital:	So. NH Internal Medicine	VA Hospital
	Other Doctor	Other:

Do you have a permanent residence? Yes No | **Section 8? Yes No**

If No, where did you spend last night?

Shelter	Unsheltered	Transitional Housing	Doubling Up	Agency/Facilities
Ash Street-03060	03060	Veteran's First -03060	Couch Surfing	Hospital
Kinsley Street-03060	Street	Key Stone-03060	Family	Jail/Prison
Maple Street-03060	Park	Laton House-03060	Friends	Other
Rescue Mission-03061	Tent	Mary's House-03060		
		SAFE Haven-03064		
		YMCA-Temple St-03060		

Is your primary language English? Yes No **If no, what is your Primary Language?**

Do you need an interpreter? Yes No

Are you deaf or hard of hearing? Yes No

Do you need a sign language interpreter? Yes No

Estimated Household Income: | **Family Size:**

Circle one: Monthly Income OR Annual Income

Some of our grants ask us to report on the race and ethnicity of the people we serve. Your information will not be shared with your name—it will only be shared as a summary of all people we serve. Responses to these questions are optional.	
Race: o White o Black/African American o Asian o More than one race	o Native Hawaiian o Other Pacific Islander o American Indian or Alaskan Native o I do not want to respond
Ethnicity: o Non-Hispanic/Latino	o Hispanic/Latino

Have you ever served in the Military?	Yes	No		
What is your discharge status?	Honorable	General	Other	

In case of an emergency, who may we contact for you?		
Name		
Street/City/State/Zip Code		
Cell Phone #		Home Phone #:
Work #		Other Phone #:
This person is your:	o Parent o Brother o Sister o Spouse o Partner	o Other Relative o Friend o Other

Harbor Care Health and Wellness Center: Patient Acknowledgements	
✓	Patient Rights and Responsibilities
✓	Notice of Privacy Practices
I understand these policies are available for review at my request.	
X	
	Signature / Date

Harbor Care Health and Wellness Center: Patient Authorizations and Consent	
✓	I hereby accept and consent to the services provided by Harbor Care Health and Wellness Center.
✓	I acknowledge that I am responsible for payment for services received at Harbor Care Health and Wellness Center.
X	
	Signature / Date
Please complete this box if you have any type of insurance coverage. *Please provide your insurance card so that we may scan the information.*	
I hereby authorize release of Personal Health Information (PHI) or any other information necessary to process payment for services provided by Harbor Care Health and Wellness Center.	
X	
	Signature / Date

Name: _____ Date of Birth: _____

Family Health History

Please use the following Letters to identify family history: M- mother, **F** – father**, B** – brother, **S** – sister,

Are you allergic to any food or medication? **YES NO** If yes, please list:

HEALTH HISTORY

	You ✓	Family		You ✓	Family
Alcohol / Drug abuse			Head injury		
Anemia			**Heart disease** (stroke, heart attack)		
Asthma or bronchitis			**High Blood Pressure**		
Behavioral Health			HIV/AIDS		
Bladder Problems or Kidney Disease			Liver Disease or Hepatitis		
Broken Bones/Fractures			Pneumonia		
Cancer or tumors			Skin Problems		
Diabetes			Stomach/Bowel Problems		
Drug and/or Alcohol Abuse			Thyroid Problems		
Ear/Hearing Problems			Tooth problems		
Emotional/Nervous/Mental Problems			Tuberculosis (TB) or TB exposure		
Epilepsy or Seizures or Blackouts					
Eye or Vision Problems					
Gyn problems or miscarriages					

For any item you answered "YES", please provide more information below or if there are any additional medical problems we should know about:

FOR FEMALES PATIENTS ONLY: Date of last menstrual period _____

Date of last PAP smear: _____ Have you ever had an abnormal PAP? **YES NO**

Have you ever had a mammogram? **YES NO** Date and results: _____

Have you ever been hospitalized for:	**YES**	**NO**	**When**	**What**
A serious accident or injury?				
An emotional or nervous problem?				
Surgeries?				
Emergency room in last year?				
X-rays in the past year?				

Do you have chronic pain (pain lasting for > 6 months)? **YES** **NO** If yes, where is the pain? _____

What treatment have you tried? _____

Do you have pain today? **YES** **NO**

On a scale of 0 to 10, 0 being no pain, 10 being horrible, how bad is your pain today? _____

When was the last time you went to the dentist? _____

When was your last tetanus shot? _____ Other vaccines: _____

Please list any medications you take that are prescribed by a doctor:

Name of medication	**Dose**	**How often?**	**Why?**	**Who prescribed it?**

Please list any non-prescription medications such as vitamins, over the counter medicines or herbal supplements:

What	**How Much?**	**How often?**	**Why?**	**Who recommended it?**

HCHWC History and Risk Assessment

Are you sexually active? **YES NO** With: Men Women Both # sexual partners in the last year? _____

If you are female, are you using birth control? **YES NO** If yes, what type? _____

Do you use condoms to protect against STIs (sexually transmitted infections) and HIV? **YES NO**

Have you been tested for HIV? **YES NO** When? _____ Result: _____

Have you ever been tested for hepatitis? **YES NO** When? _____ Result: _____

Have you ever had an STD? **YES NO** When? _____ What? _____

What is your highest level of education?

Grade school Some HS HS graduate GED Some college College degree Masters degree

Are you currently concerned about safety, abuse or violence at home or with others? **YES NO**

Have you experienced abuse in the past? **YES NO** **Type:** Emotional Physical Sexual

Who are or were the people causing the problems?

Circle all that apply:
Spouse Partner Child Mother Father Other relative Classmate Neighbor Co-worker

Have you ever been in treatment for:	**Yes**	**No**	When	Where/what program
An emotional, nervous or mental problem?				
A drug or alcohol problem?				

Do you use tobacco products? Currently In the past If you already have quit, how long ago? _____
Age Started: _____ How many per day? _____ Would you like to quit? YES NO I already have

Do you use drugs or alcohol? Currently In the past Drug/alcohol of choice : _____

When did you last use? _____ How often do you use? _____

How much? _____ Would you like to quit? YES NO

Have you ever detoxed? YES NO If yes, how long have you been clean/sober? _____

Have you ever been arrested or been in jail or prison? YES NO When? _____ How long? _____

Care Coordination: To help us coordinate your care, please list any agencies and/or programs you are working with.

Program	**Case Worker**	**Phone Number**
Addiction treatment counselor		
Mental health counselor/psychiatrist		
Vocational Rehab		