NEW PATIENT INTAKE FORM
University of Bridgeport – Health Sciences Center
60 Lafayette St. Bridgeport, CT 06604 (203) 576-4349

PLEASE COMPLETE THE FOLLOWING INFORMATION
PLEASE NOTE THAT ALL INFORMATION YOU PROVIDE WILL BE HELD IN STRICT CONFIDENCE AND WILL NOT BE DIVULGED TO OTHERS WITHOUT YOUR AUTHORIZATION

Personal Information_____ FILE No: _____

Today's Date_____
Last Name:_____First Name:_____ MI:_____

DOB:_____ Social Security number:_____

Age: ____ Sex: M □ F □ ETHNICITY: Caucasian____African-American/Black____Asian_____Hispanic____Other_____

Address:_____City:_____State_____Zip:_____

Home Phone: (___)_____ Work: (___)_____ Cell: (___)_____

Please check at least one phone number where we may contact you? Preferred: Home_____ Work_____ Cell _____

E-Mail Address:_____ May we email you reminders and other clinic information? [ ]Yes [ ]No

Occupation: _____FULL/PART TIME

Married_____ Single_____ Divorced_____ Widowed/Widower_____ Committed Relationship_____

Spouse's Name_____ Phone number:_____

Person to Notify in Case of Emergency_____Phone:_____

Relationship:_____

MEDICAID □ No □ Yes MEDICARE □ No □ Yes

If the patient is under the age of 18:

Name of Mother_____ Phone No. (____)_____

Name of Father_____ _____ Phone No. (____)_____

Legal Guardian:_____ Relationship:_____ Phone (____)_____

Is this condition or problem caused by an auto accident? .....> □ No □ Yes
Is this condition or problem related to your current or former job? .....> □ No □ Yes

Are you a University of Bridgeport student or employee? □No □Yes
If **"NO", skip to the next section. If "YES", please continue to fill out this section.**
Are you seeking care for an injury or condition that occurred on the UB campus? **□ No □Yes**
Are you an employee seeking care for a work related injury or condition? **□ No □Yes**
Have you missed work because of your injury? **□ No □Yes**

Are you a UB intercollegiate student-athlete? □ No □Yes
If "NO", skip to the next section. If "YES", please continue to fill out this section.
Is your visit to the Clinic related to an injury or condition that developed in connection with a UB athletic event or practice, whether in or out of season? **□ No □Yes**

PRESENT COMPLAINT(S)

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

In the space below, please describe the present complaint(s) which brought you to the UB Health Sciences Clinic for care. After completing this first section, please complete the questionnaire on the following page. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

What is your most important reason for making this appointment with our clinic?_____

DID YOU GO TO THE HOSPITAL OR EMERGENCY ROOM FOR <u>THIS</u> CONDITION?

- □ **NO If "NO" skip to the next section.**
- □ **YES If "YES, please continue to fill out this section.**

Name of Facility_____ Location:_____
Did you go: □ Immediately after onset of condition □ Delayed until later that day or following day(s)
Did you go to the hospital by: □ Ambulance □ Car □ Other:_____
Were x-rays taken? □No □ Yes If yes, of what body region(s)?_____
What was your diagnosis?_____ What treatment did you receive?_____
Did they recommend any follow-up treatment? □ No □ Yes If yes, what?_____

When did your main problem begin (*a specific date if possible)?* _____
Did your problem begin:
□ Immediately after a specific incident □ After multiple incidents □ Gradually developed over time □ No specific reason noted
Briefly describe how your problem began: _____
_____
What makes your problem BETTER?
□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity □ Nothing
□ Hot □ Cold □ Other _____
What makes your problem WORSE?
□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity □ Nothing
□ Hot □ Cold □ Other _____
How often are the complaints present?
□ Constant (76-100%) □ Frequent (51 – 75%) □ Occasional (26-50%) □ Intermittent (25% or less)
Since your problem began the pain has: □ Increased □ Decreased □ Not changed
What treatment have you received for this present condition?
□ No treatment (professional or self treatment) □ Medication(s) (Rx and OTC):_____
□ Physical Therapy □ Chiropractic □ Acupuncture □ Injections □ Surgery □ Other:_____

Please list any other medical/health concerns you would like to have addressed:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Where and when did you last receive health care? _____

Please list any hospitalizations and surgeries you have undergone:
_____

_____
Please list any serious trauma you have had, such as an accident or fall:
_____

Please list any foods, drugs or other substances to which you have allergic, anaphylactic or other adverse reactions. (Please specify if anything has caused you to have an anaphylactic reaction): _____

_____

_____

Please list all vitamins, minerals, amino acids, food supplements and herbs that you are currently taking:

_____

_____

Please list all medications – prescription and over-the-counter, that you are currently taking:

_____

_____

Have you ever had an adverse reaction to an immunization? Y[] N[] If yes, which immunization:_____

Have you ever had an adverse reaction to any medication, supplement, herb or recreational drug? Y [] N []

If yes, which?_____

Have you ever been exposed to:

The AIDS virus (HIV)	[] yes	[]no
Tuberculosis (TB)	[] yes	[]no
Hepatitis virus (A, B or C)?	[] yes	[]no

Do you have any concerns about AIDS, TB or hepatitis that you would like to discuss? [] yes []no

Do you currently have a productive cough? [] yes []no

How did you hear about our clinic?_____

Have you been previously treated by any of the following:

Naturopathic Physician [ ] Acupuncturist [ ] Chiropractic Physician [ ]

Under what circumstances?_____

Family Medical History: To the best of your knowledge, has your mother, father, siblings or grandparents ever had any of the following? [ ] Adopted/don't know

[ ] High cholesterol	[ ] Thyroid disease	[ ] Osteoporosis	[ ] Mental illness
[ ] Anxiety/panic attacks	[ ] Asthma	[ ] Eczema	[ ] Allergies
[ ] Arthritis	[ ] Heart disease/Hypertension	[ ] Stroke	[ ] Depression
[ ] Ulcerative colitis	[ ] Crohn's disease	[ ] Autoimmune disease	[ ] Alzheimer's
[ ] Alcoholism	[ ] Kidney disease	[ ] Cancer	[ ] Diabetes
[ ] Obesity	[ ] Other serious illness (please list here): _____		

How would you grade your overall stress level?

□ No stress □ Minimal stress □ Moderate stress □ Greatly stressed

Physical activity at work:

□ Sitting more than 50% of the work day □ Light manual labor □ Moderate manual labor
□ Heavy manual labor

General physical activity

□ No regular exercise program □ Light exercise program □ Strenuous exercise program

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IF IN PAIN NOW, PLEASE COMPLETE THE SECTION BELOW. IF NOT CURRENTLY IN PAIN, PLEASE SKIP TO THE NEXT PAGE

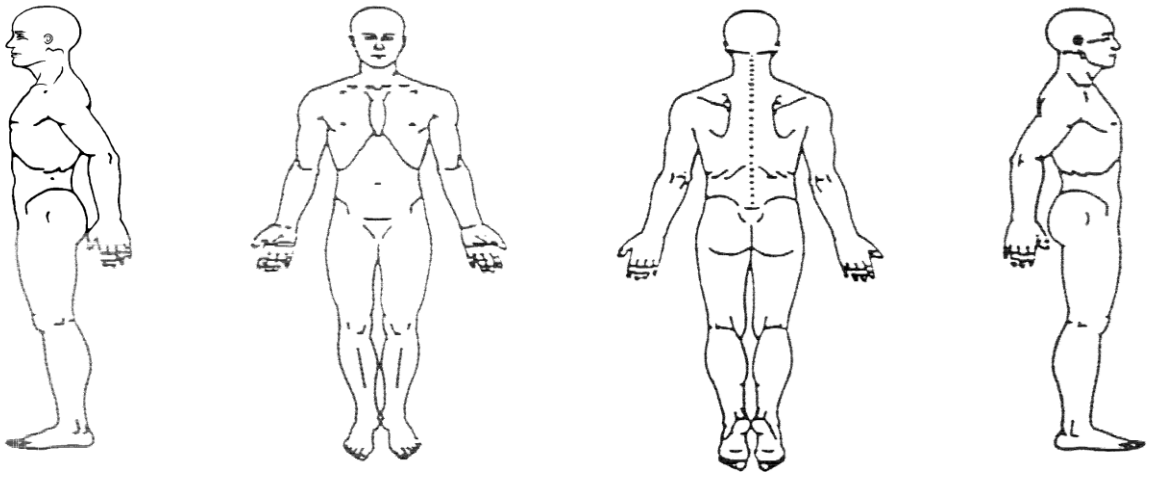
I AM CURRENTLY IN PAIN [] yes []no

PAIN DRAWING AND PAIN SCALE

Please locate and mark the quality of your pain on the body outlines provided.

Please use the code letters as indicated below:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing X = Other



Please Mark Your Level of Pain Below:

No Pain ----------Worst Pain

1 2 3 4 5 6 7 8 9 10

What percent of the time is your pain at this level? _____%

I hereby acknowledge by my signature that I am authorizing the UB Health Sciences personnel assigned to my case to perform whatever diagnostic procedures that they may deem medically necessary in order to adequately evaluate my condition. I am also aware that this evaluation may be performed by a student intern who is under the supervision of a licensed clinician.

The information above is complete and accurate to the best of my ability.

Patient's Signature: _____ Date:_____

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

N = Never S = Sometimes O = Often

N S O CONDITION	N S 0 CONDITION	N S O CONDITION
General Symptoms: □ □ □ Headache □ □ □ Nervousness □ □ □ Tension □ □ □ Anxiety □ □ □ Irritability □ □ □ Depression □ □ □ Cold Hands or Feet □ □ □ Night Sweats □ □ □ Cold Sweats □ □ □ Excessive Thirst □ □ □ Abnormal Weight Loss □ □ □ Abnormal Weight Gain □ □ □ General Fatigue □ □ □ Sleep Problems – Insomnia **Musculoskeletal :** □ □ □ Neck Pain □ □ □ Neck Stiffness □ □ □ Jaw Pain □ □ □ Shoulder Pain □ □ □ Hand Pain □ □ □ Upper Back Pain □ □ □ Lower Back Pain □ □ □ Pain in ankle or knee □ □ □ Joint Swelling □ □ □ Stiffness of Joint(s) □ □ □ Arthritis □ □ □ Pain in Upper Leg or Hip □ □ □ Pain in Lower Leg or Knee **Neurological symptoms:** □ □ □ Numbness in Fingers □ □ □ Numbness in Toes □ □ □ Pins and Needles □ □ □ Fainting □ □ □ Loss of Consciousness □ □ □ Seizures/Convulsions □ □ □ Dizziness □ □ □ Balance Problems □ □ □ Coordination Problems □ □ □ Ringing in the Ears □ □ □ Memory Problems □ □ □ Eyes Sensitive to Light □ □ □ Loss of Smell	**Cardiovascular Symptoms:** □ □ □ Palpitations (Racing Heart) □ □ □ Chest Pains (Angina) □ □ □ Shortness of Breath □ □ □ High Blood Pressure □ □ □ Low Blood Pressure □ □ Stroke: Date: _____ □ □ Heart Attack: Date_____ □ □ Coronary Artery Bypass □ □ Pacemaker for Heart **Respiratory Symptoms:** □ □ □ Asthma □ □ □ Chronic Cough □ □ □ Chronic Sinusitis □ □ □ Lung Problems □ □ □ Allergic rhinitis **Urinary System Symptoms:** □ □ □ Frequent Urination □ □ □ Painful Urination □ □ □ Kidney Stones □ □ □ Bladder Disorder □ □ □ Kidney Disorder □ □ □ Prostate Problem □ □ □ Loss of Bladder Control **Other Chronic Issues:** □ □ □ Skin Problems – Rash □ □ □ Diabetes □ □ □ Anemia □ □ □ Other Blood Disorder(s) _____ □ □ Cancer: Type_____ _____ □ □ Other Condition(s): _____ _____ _____	**Digestive Symptoms:** □ □ □ Nausea □ □ □ Vomiting □ □ □ Loss of Appetite □ □ □ Upset Stomach □ □ □ Constipation □ □ □ Diarrhea □ □ □ Heartburn Indigestion □ □ □ Loss of Bowel Control □ □ □ Ulcer □ □ □ Colitis □ □ □ Irritable Colon □ □ □ Anorexia/Bulemia □ □ □ Difficulty Swallowing _____ **General Health:** Height: _____ Weight: _____ **Date of Last:** Physical Exam:_____ X-ray Exam:_____ Blood Test: _____ _____ **Women – Please fill out this section:** □ Pregnant: Total No.:_____ No. to Term:_____ □ □ □ Irregular Menses □ □ □ Profuse Menses □ □ □ Scanty Menses □ □ □ PMS □ □ □ Menstrual cramps □ □ □ Use Birth Control Pills □ □ □ Sore Breast(s)/Lumps □ □ □ Endometriosis □ □ □ Vaginal Discharge **Date of Last Menses:** _____ _____ **SOCIAL HISTORY** □ □ □ Use Tobacco □ □ □ Use Alcohol □ □ □ Use Recreational Drugs □ □ □ Victim of Physical Abuse

Notice to Pregnant Women: All female patients must inform the supervising clinician if they know or suspect they are pregnant as some procedures and therapies described herein may present a risk to the pregnancy.

Notice to Minors seeking services and their parents/guardians: Special consent form is required for minor patients seeking services at the Health Sciences Center clinics. Please request this form from the front desk and complete with your health personnel during consultation prior to treatment.

The questions/diagrams and other information on this 6-page form have been answered completely and truthfully to the best of my knowledge. I understand that withholding medical information may compromise the ability of the staff interns and clinicians to diagnose and treat my condition.

Signature_____

I understand that the University of Bridgeport Health Sciences Center is a teaching **and research** facility. As such, I hereby give my consent to allow students and/or faculty to observe my visits and/or treatments for educational purposes. I also understand that the clinics may create, **analyze, publish** and distribute **anonymous** health information by removing all references to individually identifiable information for research, assessment, training and other normal operations of a teaching **and research clinic**. I realize I may terminate this permission at any time by providing a written request to the clinical supervisor or Senior Services Administrator without any consequence or effect upon my care. (See HIPAA notification for details of these privileges.)

Patient Financial Agreement

I understand the payment is due at the time services are rendered, unless prior financial arrangements have been made. In order to receive a discount on your visit, payment must be made at the time of service. If payment is **NOT** made at the time of service, you will **NOT** receive a discount (example: TOS, Medicaid, Medicare or Student, etc.) and you will be responsible for the full amount of your visit.

I, _____, have read the above information and I understand the information provided within this document. This information has been explained to me and all questions which I have asked have been answered to my satisfaction.

_____ _____

Signature Date

Print name here

If the patient is a minor or unable to consent:

_____

Signature of person legally responsible for the patient

_____

Date

Print name of person legally authorized here