CROSSROADS CLINIC VOLUNTEERS IN MEDICINE

Intake Assessment Information

Medical Record # _____

Patient Name: _____ Maiden Name: _____

Street Address: _____ City, State, ZIP _____

County of residence: _____ Note: **Proof** of residency must be provided

Patient Birth date: _____ Name of Spouse: _____ Spouse birth date: _____

Patient phone # _____ Number of family members in household (including yourself & spouse): _____

Email Address: _____ Veteran: Yes No

Employment Information: **Patient** **Spouse**

Name of Employer: _____ _____

Street Address: _____ _____

City State Zip: _____ _____

Previous year Federal Income Tax Forms (Form 1040 pages 1 & 2)

Children's Names and birth dates:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Income Data for Family (List all sources and amounts of income for your family.)

Source of Income (employer etc)	Gross before deductions	Monthly or yearly
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge I have provided accurate information.

Signature of Patient: _____ Date: _____

One proof of residency has been provided: YES NO

CROSSROADS CLINIC VOLUNTEERS IN MEDICINE

HISTORY & PHYSICAL

Name: _____ **MR#:** _____ **DOB:** _____

Address: _____ **Occupation:** _____

CHIEF COMPLAINT: _____

DRUG ALLERGIES

_____
_____
_____
_____
_____
_____
_____

CURRENT MEDS

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: **Pregnant?** ☐ YES ☐ No **Planning Pregnancy?** ☐ YES ☐ No

MEDICAL HISTORY

- ☐ Headache _____
- ☐ Shortness of breath _____
- ☐ Heart palpitations _____
- ☐ Heart murmur _____
- ☐ Chest pain _____
- ☐ Dizziness/Fainting _____
- ☐ Peripheral vascular disease _____
- ☐ Allergies/Hay fever _____
- ☐ Asthma _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ Ulcer _____
- ☐ GI disorder _____
- ☐ Lactose Intolerance _____
- ☐ Gallbladder disease _____
- ☐ Prostate disease _____
- ☐ Bowel irregularity _____
- ☐ Incontinence _____
- ☐ Sexual/menstrual dysfunction _____
- ☐ Venereal disease _____
- ☐ Frequent infections _____
- ☐ Hepatitis _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Osteoporosis _____
- ☐ Nervousness _____
- ☐ Depression _____
- ☐ Gout _____
- ☐ Scarlet fever _____
- ☐ Chronic rashes _____
- ☐ Rheumatic fever _____
- ☐ Mumps _____
- ☐ Measles _____
- ☐ Rubella _____
- ☐ Polio _____
- ☐ Diphtheria _____
- ☐ Tetanus _____
- ☐ Other _____
- ☐ Other _____

HABITS

- ☐ Smoke: Packs Daily _____
  How long? _____
  Interested in stopping? ____
- ☐ Exercise routine: _____
  _____
  _____
- ☐ Coffee: Cups Daily _____
  Other Caffeine _____
- ☐ Alcohol: Type _____
  Amount _____
- ☐ Diet: Salt intake _____
  Fat intake _____
- ☐ Sleep: Difficulty falling asleep _____
  Continuity disturbances _____
  Snoring _____
  Early morning awakening _____
  Daytime drowsiness _____
  Other _____

HEPATITIS C RISK FACTOR

- ☐ Blood Transfusion prior to 1992
- ☐ IV drug use (1+ times)
- ☐ Contact with blood/bodily fluids
- ☐ Tattoos
- ☐ Shared razor/toothbrush
- ☐ Body Piercing

MISCELLANEOUS NOTES:

_____
_____
_____
_____