NEW PATIENT INTAKE FORM
University of Bridgeport – UB Clinics
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/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 Clinics 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 THIS 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) □**No** □**Yes**

Tuberculosis (TB) □**No** □**Yes**

Hepatitis virus (A, B or C)? □**No** □**Yes**

Do you have any concerns about AIDS, TB or hepatitis that you would like to discuss? □**No** □**Yes**

Do you currently have a productive cough? □**No** □**Yes**

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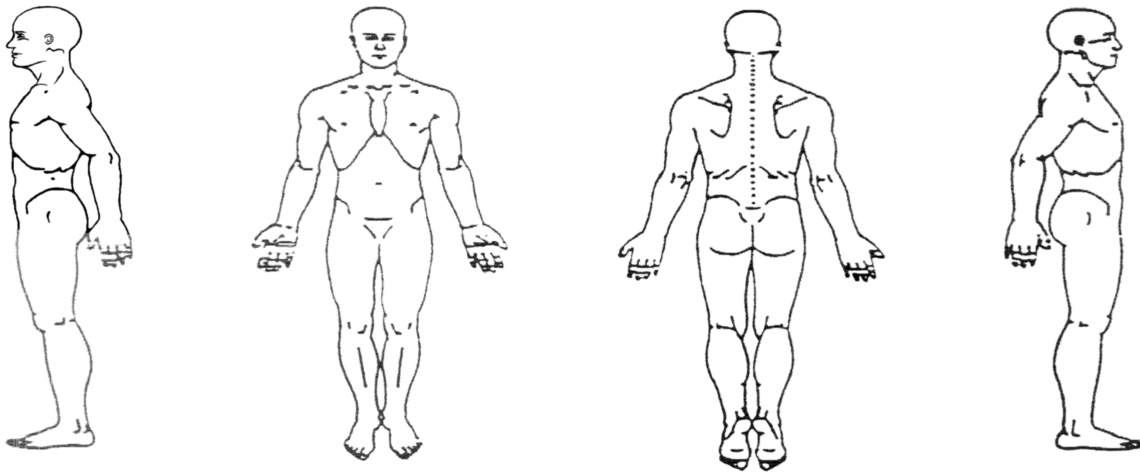
IF IN PAIN NOW, PLEASE COMPLETE THE SECTION BELOW. IF NOT CURRENTLY IN PAIN, PLEASE SKIP TO THE NEXT PAGE

I AM CURRENTLY IN PAIN **□No □Yes**

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 Clinics 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

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

N S 0 CONDITION

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):
____
____
____

N S O CONDITION

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 UB 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 UB Clinics 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 Clinical Services & Operations Administrator without any consequence or effect upon my care. (See Notice of Privacy Practices for details of these privileges.)

Patient Financial Agreement

I understand that 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