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

*Please note that the University of Bridgeport Health Sciences Center is **a teaching and research** facility. As such, please be aware that students and/or faculty may observe my visits and/or treatments for educational purposes.*

PLEASE COMPLETE THE FOLLOWING INFORMATION IN PEN. 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

Today's Date_____

Last Name: _____ First Name: _____ MI: _____ DOB: _____

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-TIME _____ PART-TIME _____

Married _____ Single _____ Divorced _____ Widowed/Widower_____ Committed Relationship_____

Person to Notify in Case of Emergency_____ Phone: _____

Contact's Relationship to you: _____

MEDICAID □ Yes □ No **MEDICARE** □ Yes □ No

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? _____

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. _____

Where and when did you last receive health care? _____

Please list any significant hospitalizations and surgeries you have undergone (dates if available):

_____

_____

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? □ Yes □ No If yes, which immunization: _____

Have you ever had an adverse reaction to any medication, supplement, herb or recreational drug? □ Yes □ No

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 currently have a productive cough?	□ Yes □ No

How did you hear about our clinic? _____

Have you been previously treated by any of the following types of practitioners:

Naturopathic Physician [ ] Acupuncturist [ ] Chiropractic Physician [ ]

Under what circumstances?_____

Medical History: To the best of your knowledge, do you have or have you ever had any of the following?

[ ] 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): _____		

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

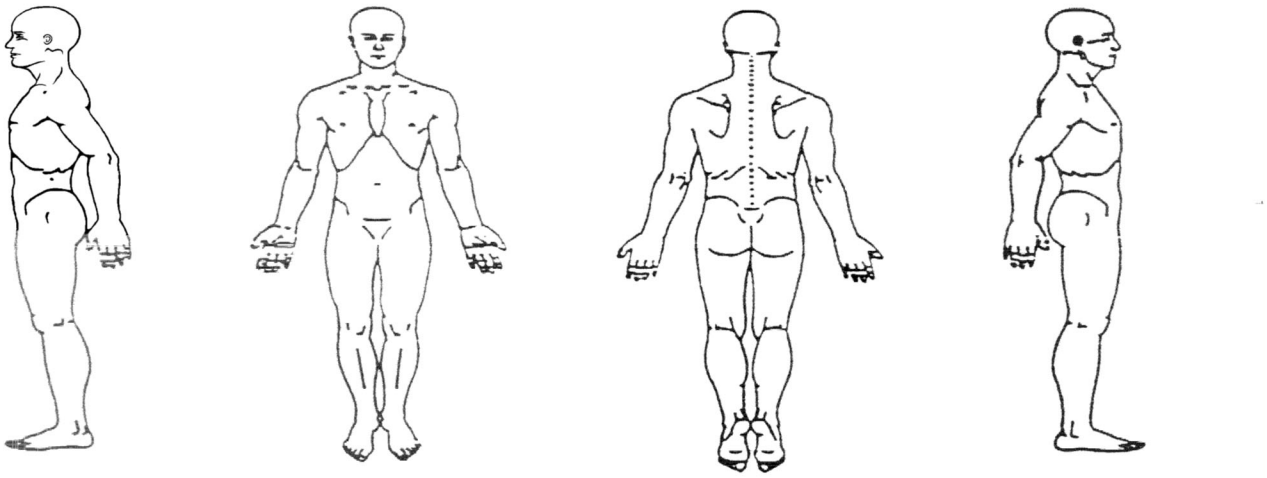
I AM CURRENTLY IN PAIN □ Yes □ No

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:_____

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: A 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 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.

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 Clinical Services & Operations Administrator without any consequence or effect upon my care. (See HIPAA notification for details of these privileges.)

Financial Agreement: Payment for all services is due at the time of the visit. We accept the following forms of payment: Cash, Check, Credit Card – Visa, MasterCard, Discover, and American Express.

I acknowledge that I was provided with a copy of the UB Clinics Notice of Privacy Practices (NOPP).
□ Received □ Declined

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