

Healing Hands Community Clinic

Patient Intake Form

Please complete this form as accurately as possible. If you need assistance, please ask a clinic staff member.

1. Patient Information

Full Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____

Preferred Language: _____

Phone Number: _____

Email Address: _____

Home Address: _____

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Phone: _____

2. Reason for Today's Visit

What brings you to the clinic today?

When did this problem or concern begin?

Have your symptoms changed recently?

☐ Yes ☐ No

If yes, please explain:

What concerns you most about your health today?

3. Current Symptoms

Please check any symptoms you currently have:

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Headache
- ☐ Dizziness
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sore throat
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Back pain
- ☐ Joint or muscle pain
- ☐ Rash or skin changes
- ☐ Swelling
- ☐ Pain with urination
- ☐ Changes in urination
- ☐ Changes in bowel movements
- ☐ Anxiety or depression symptoms
- ☐ Other: _____

4. Medical History

Have you ever been diagnosed with any medical conditions?

- ☐ No ☐ Yes

If yes, please list them:

Have you ever had surgery or been hospitalized?

- ☐ No ☐ Yes

If yes, please describe and include approximate dates if known:

Have you had any major injuries or accidents?

- ☐ No ☐ Yes

If yes:

5. Medications

Are you currently taking any medications, vitamins, or supplements?

☐ No ☐ Yes

Please list the name, dose (if known), and how often you take each:

Medication / Supplement	Dose	How Often

6. Allergies

Do you have any medication, food, or other allergies?

☐ No known allergies
☐ Yes

Please list allergies and reactions:

7. Family Medical History

Has anyone in your immediate family had any of the following?

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer
- ☐ Asthma or lung disease
- ☐ Kidney disease
- ☐ Mental health condition
- ☐ Other: _____

Additional family medical history:

8. Social & Lifestyle Information

Do you currently use tobacco or nicotine products?

☐ No ☐ Yes ☐ Former user

Do you currently drink alcohol?

☐ No ☐ Yes

Do you currently use recreational drugs or other substances?

☐ No ☐ Yes

Do you have concerns about substance use that you would like to discuss with a medical provider?

☐ No ☐ Yes

How would you describe your living situation?

☐ Stable housing

☐ Temporary housing

☐ Staying with family/friends

☐ Shelter

☐ Currently without housing

☐ Other: _____

9. Women's/Reproductive Health — If Applicable

Are you currently pregnant or could you be pregnant?

☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Date of last menstrual period: _____

Are you currently using birth control?

☐ No ☐ Yes ☐ Not applicable

Any reproductive or gynecological concerns you would like to discuss?

10. Preventive Care

When was your last general medical checkup?

Do you know when you last received the following?

Flu vaccine: _____

COVID-19 vaccine: _____

Tetanus/Tdap vaccine: _____

Other vaccines: _____

Last dental visit: _____

Last vision/eye exam: _____

11. Preferred Communication

How would you prefer the clinic to contact you?

☐ Phone call

☐ Text message

☐ Email

☐ Other: _____

Is it okay for the clinic to leave a voicemail?

☐ Yes ☐ No

Is it okay for the clinic to send text messages regarding appointments or medical care?

☐ Yes ☐ No

12. Additional Information

Is there anything else you would like your medical provider to know?

13. Patient Acknowledgment

I confirm that the information I have provided on this form is accurate and complete to the best of my knowledge. I understand that I should tell the medical provider if any of my health information changes.

Patient/Parent/Guardian Name: _____

Signature: _____

Date: _____

If completed by someone other than the patient, relationship to patient:

FOR CLINIC USE ONLY

Date of Visit: _____ **Time:** _____

Patient ID: _____

Provider: _____

Vital Signs:

BP: _____ **Pulse:** _____ **Resp:** _____

Temperature: _____ **SpO₂:** _____

Weight: _____ **Height:** _____

Primary Concern/Diagnosis:

Additional Notes:

Follow-Up Needed:

☐ No

☐ Yes — Date/Instructions: _____

Referrals/Resources Provided:

Healing Hands Community Clinic

PATIENT INTAKE FORM

Date: _____ Patient Name: _____

DOB: _____ Age: _____ Preferred Name: _____

Phone: _____ Preferred Language: _____

Address: _____

REASON FOR VISIT

Main concern: _____

When did it begin? _____ Pain (0–10): _____

CURRENT SYMPTOMS

☐ Fever ☐ Headache ☐ Dizziness ☐ Chest pain ☐ Shortness of breath ☐ Cough
☐ Sore throat ☐ Nausea/Vomiting ☐ Diarrhea ☐ Abdominal pain ☐ Back/Joint pain
☐ Rash ☐ Urinary problems ☐ Fatigue ☐ Anxiety/Depression ☐ Other: _____

MEDICAL HISTORY

Medical conditions: _____

Surgeries/Hospitalizations: _____

Current medications/supplements: _____

Allergies: ☐ None known ☐ Yes: _____

FAMILY & SOCIAL HISTORY

Family history: ☐ Diabetes ☐ Heart disease ☐ High BP ☐ Stroke ☐ Cancer ☐ Other: _____

Tobacco/Nicotine: ☐ Never ☐ Current ☐ Former Alcohol: ☐ No ☐ Yes

Recreational drugs/substances: ☐ No ☐ Yes

REPRODUCTIVE HEALTH — IF APPLICABLE

Pregnant/possibly pregnant: ☐ No ☐ Yes ☐ Unsure ☐ N/A

Last menstrual period: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

ADDITIONAL INFORMATION

Patient/Guardian Signature: _____ Date: _____

—

FOR CLINIC USE

BP: _____ Pulse: _____ Temp: _____ SpO₂: _____ Weight: _____

Assessment/Notes:

Plan/Treatment:

Follow-up: ☐ None ☐ Return in: _____ ☐ Referral: _____

Provider Signature: _____ Date: _____

Healing Hands Community Clinic

FOLLOW-UP VISIT FORM

Date: _____ Patient Name: _____

DOB: _____ Phone: _____

Provider: _____ Last Visit Date: _____

REASON FOR FOLLOW-UP

What are you following up on today?

Has the problem improved, stayed the same, or gotten worse?

☐ Improved ☐ Same ☐ Worse ☐ Resolved

Please describe any changes:

CURRENT SYMPTOMS

☐ None ☐ Fever ☐ Pain ☐ Headache ☐ Dizziness ☐ Cough

☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Abdominal pain

☐ Rash/Skin changes ☐ Urinary problems ☐ Fatigue ☐ Other: _____

Pain today (0–10): _____

MEDICATIONS

Are you taking your medications as directed?

☐ Yes ☐ No ☐ Not taking medication

Any medication changes, side effects, or problems?

Current medications/supplements:

SINCE YOUR LAST VISIT

Any new medical problems, illnesses, injuries, ER visits, or hospitalizations?

☐ No ☐ Yes — Please explain:

Any new allergies? ☐ No ☐ Yes: _____

Any changes in tobacco, alcohol, or substance use? ☐ No ☐ Yes

PATIENT CONCERNS

What questions or concerns would you like to discuss today?

CLINIC USE ONLY

Vital Signs:

BP: _____ **Pulse:** _____ **Temp:** _____ **SpO₂:** _____ **Weight:** _____

Assessment/Notes:

Plan/Treatment:

Follow-up: ☐ None ☐ Return in: _____ ☐ Referral: _____

Provider Signature: _____ **Date:** _____