ABIDE Health Medical
6847-B West Charleston Blvd
Las Vegas, NV 89117
Phone: 725-205-1578 / eFax: 725-485-3749

Patient Intake Form

Patient Demographics

Name:	DOB:	Date of Intake
Address:		SS#:
Email:		Phone #:
Leave Message Okay: ☐ Yes ☐ No	Text Reminder Okay: ☐Yes ☐No	

Marital Status:	DOB:	Gender:	Ethnicity:
Emergency Contact / Guardian:		Relationship to You:	
Email:		Phone #:	
Preferred Communication: ☐ Text ☐ Email ☐ Call		Language:	

Race: ☐ Native American ☐ Asian ☐ Black or African American ☐ Pacific Islander
☐ White ☐ Others Please Specify :_____

Preferred Pharmacy:	
Pharmacy Address:	Phone:

Primary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:

Relationship with the Insured:
Person Responsible for Account:

Secondary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	
Person Responsible for Account:	

Medical History

Primary Care Provider:	Phone #:

List all current physicians and/or practitioners you currently use.

Name	Specialty

Current Medical Issues/ Chronic Illness / Diagnosis/ Health Concerns:

Pain

Are you experiencing Pain? ☐Yes ☐ No	Location of Pain?
How Long?	Medication(s) Used for Pain?
Pain Level Today: Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe	

Prescriptions

List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency	Prescribed By

Medical Information

How would you rate your overall health?	☐Excellent	☐ Good	☐ Fair	☐ Poor
Weight: Height:	☐ Appetite:	☐ Good	☐ Fair	☐ Poor
List any vaccines you've had in the last year:				
Allergies:				

Surgeries/Hospitalizations

Type of Surgery / Hospitalization	Date

Social History

Immediate Family Members Living with Patient			
Name	**Gender**	**Age**	**Relationship to Patient**

Education/ Employment: Years of Education:	Degree(s):

Currently Employed: ☐Yes ☐ No ☐ Satisfied ☐Unsatisfied

☐ Never employed ☐ Self-employed ☐ Student

☐ Full-time ☐ Temporary/Seasonal ☐ Disabled

☐ Part-time ☐ Retired ☐ Other: _____

Been Fired: ☐ Yes ☐ No ☐ Problems with Employer ☐ Problems with co-workers

Tobacco Use: ☐ Yes ☐ No	**Alcohol Use:** ☐ Yes ☐ No
If yes, how many packs a day:	If yes, how many drinks a day/week:
Number of years:	☐ Beer ☐ Wine ☐ Liquor
Have you ever stopped? ☐ Yes ☐ No	Have you been told your drinking is a concern? ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No Drug of choice? Ever used needles: ☐ Yes ☐ No	Notes:

Exercise: Do you exercise regularly? ☐ Yes ☐ No	What kind of exercise? Duration: Frequency:

Sleep: How many hours on average do you sleep a night?	Trouble falling asleep? ☐ Yes ☐ No	Trouble staying asleep? ☐ Yes ☐ No

Emotions: In the past year, have you had 2 or more weeks when you'd felt sad, depressed or lost interest in things you once enjoyed?	☐ Yes	☐ No
Have you felt depressed or sad much of the time in the past year?	☐ Yes	☐ No
Do you find yourself so anxious that you isolate yourself or avoid situations?	☐ Yes	☐ No
Do you ever feel like hurting yourself or others?	☐ Yes	☐ No
Is there anything else you would like us to know about how you feel?		

Have you ever had a head injury (sometimes referred to as a 'Traumatic Brain Injury (TBI)' or 'Concussion')?	☐Yes	☐ No

If 'YES,' please provide the following information:

1. Approximate Date of Injury _____
2. Cause of injury? _____
3. Did you lose consciousness? ☐Yes ☐ No - If 'YES,' for how long? _____
4. Were you taken to the hospital? ☐ Yes ☐ No - If 'YES," which hospital? _____
5. Did you receive an MRI or CAT scan? ☐ Yes ☐No

COGNATIVE CHECKLIST

Attention and Concentration (Select what problems or symptoms you have experienced)

- ❑ Staying focused at work, home, or school
- ❑ Distractibility
- ❑ Sustained attention
- ❑ Divided attention

Executive Functioning (Select what problems or symptoms you have experienced)

- ❑ Planning and organizing tasks at work, home, or school
- ❑ Poor judgment and decision making
- ❑ Impulsivity
- ❑ Inhibiting responses
- ❑ Monitoring your performance on tasks for errors
- ❑ Beginning tasks

Language (Select what problems or symptoms you have experienced)

- ❑ Understanding things that people say and/or things that you read
- ❑ Producing speech
- ❑ Finding the right word
- ❑ Tracking conversations
- ❑ Tracking your own thoughts

Visuospatial (Select what problems or symptoms you have experienced)

- ❑ Perceiving objects
- ❑ Recognizing objects
- ❑ Visual field obstructions

Sensory and Motor (Select what problems or symptoms you have experienced)

- ❑ Worsening vision
- ❑ Worsening hearing
- ❑ Worsening smell
- ❑ Worsening taste
- ❑ Decreased grip strength and dropping items
- ❑ Balance and coordination difficulties
- ❑ Tremors
- ❑ Falls

FUNCTIONAL GOALS SURVEY

What are 3-5 activities you can no longer do or are struggling to do because of this condition? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Has what you've done to date for your condition helped? ☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent
What is your biggest fear if this condition continues to progress?
What would success mean to you in our office?

My signature below certifies that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

_____ _____ _____

Signature Printed Name Date

CONSENT FOR TREATMENT

As a client of the company, you have the right to be involved in the treatment planning which will identify specific goals, objectives, and various therapeutic interventions to help manage your mental illness. You also have the right to be informed regarding your progress. Keep in mind that progress occurs at different rates for different individuals and symptoms may initially increase when addressing painful issues. However, if at any time you are experiencing significant distress or are dissatisfied with your progress or the services you are receiving, it is important to discuss this with your treatment provider. We also ask that you do not terminate treatment without a final meeting with your treatment provider to ensure appropriate closure and to provide you with any necessary referrals.

Please initial beside the treatment(s) the client agrees to participate in:

_____ **Electro Stimulator Therapy (EST)**

EST is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate. It will help you focus on making subtle changes in your body, such as relaxing certain muscles to reduce pain.

_____ **Cranial Electrotherapy Stimulation (CES)**

CES restores natural balance to mind and body using a painless, electrical microcurrent waveform, applied via ear clips on your earlobes.

_____ **Transcranial Magnetic Stimulation (TMS)**

If you are considered eligible and a willing participant as indicated by signing this release form, you agree to receive a series of “single-pulse” TMS pulses as part of the Motor Threshold Determination (MT Determination).

_____ **BrainView Cognitive Assessment (BV)**

The BV system assesses brain function to help physicians effectively measure and manage memory loss, cognitive impairment, and other stress-related neurological conditions. It can detect declines in memory markers as early as 15 years prior to the manifestation of symptoms.

_____ **VitalScan Neuropathy Assessment (VS)**

The VS assessment consists of two tests: the ANS+ and the SudoCheck+. The ANS+ test provides supplemental monitoring and optimized detection of cardiovascular, neurological, and metabolic conditions associated with many adverse health events. The SudoCheck+ test evaluates the function of small nerve fibers and sweat glands density to determine early onset of diabetes as well as other cardiometabolic risks in patients.

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DISCLOSURE

I have been fully informed and understand the information contained in this Consent for Treatment, including the limits to confidentiality and the emergency policy as described above. I acknowledge that I am providing voluntary consent for services and understand that I may withdraw my consent at any time by notifying my provider.

Legal Guardian Name: _____

Legal Guardian Signature: _____ Date: _____

Client Name: _____

Client Signature: _____ Date: _____

HIPAA Notice of Privacy Practices & Acknowledgment of Receipt
ABIDE Health Medical

ABIDE Health Medical is committed to protecting the privacy and confidentiality of your health information in compliance with applicable laws. We may use and disclose your health information for purposes related to treatment, payment, and healthcare operations—for example, coordinating care with other providers, billing insurance, or conducting internal quality assessments. In specific cases, your information may also be shared without your authorization as required by law, such as for public health reporting, law enforcement, or government functions.

You have rights regarding your health information, including the right to access and request amendments to your records, request restrictions or confidential communications, and receive an accounting of disclosures. You are also entitled to receive a paper copy of this notice upon request. ABIDE Health Medical reserves the right to revise this notice, with updated versions available upon request and posted in our facility.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Acknowledgment of Receipt

By signing below, I acknowledge that I have received and reviewed the ABIDE Health Medical Notice of Privacy Practices.

Client Name: _____

Client Signature: _____

Date: _____

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Authorization To Bill Insurance

Client: _____ Guardian (if Minor): _____

Phone: _____ Email: _____

Address: _____

Insurance Company: _____ Policy #:_____

Doctor: _____ Clinic: _____

Phone: _____ Address: _____

I, the undersigned, hereby certify and attest that I have sought evaluation treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release me or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or legal claim against me for non-payment.

Signature: _____ Date: _____