ABC FOR YOUR HEALTH, LLC

ADVOCATING BETTER CARE FOR YOU

BARBARA O'HALLORAN SMITH

Personal Intake Form

Client Information

Date: _____ Date of Birth: _____/_____/_____

Name: _____ Social Security: _____-_____-_____

Address: _____

Street City State Zip

Email Address:

_____

Home Phone: _____ Sex: M or F

Cell Phone: _____ Marital Status: _____

Work Phone: _____ Occupation: _____

Employer: _____

Employer Address: _____

Street City State Zip

If under 18 years, name of Parent or Guardian: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

How did you hear about ABC FOR YOUR HEALTH? _____ Website

_____ Client/Friend _____

_____ Doctor/Hospital _____

_____ Other _____

Client Signature: _____ Date: _____

PHONE: 508-242-3114 • FAX: 508242-3141 • ✉ B.OHALLORANSMITH@ABCFORYOURHEALTH.COM

WWW.ABCFORYOURHEALTH.COM

Client Name: _____ Date of Birth: _____/_____/_____

What are your goals in seeking services from ABC FOR YOUR HEALTH, LLC?

Short Term Goals (0-3 months):

1. _____
2. _____
3. _____
4. _____
5. _____

Long Term Goals (4 months or longer):

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have a Health Care Proxy or Advanced Directive? Yes No

Name of Health Care Proxy: _____ Relationship: _____

How do you rate your overall health? Excellent Good Fair Poor

How do you rate your overall quality of life? Excellent Good Fair Poor

Client Signature: _____ Date: _____

Health History

Name: _____ Date of Birth: _____/_____/_____

Please circle Yes or No for each condition:

Yes	No	Do you have high blood pressure?
Yes	No	Do you have heart disease?
Yes	No	Do you experience shortness of breath?
Yes	No	Do you experience angina (chest pain)?
Yes	No	Do you have lung disease?
Yes	No	Do you experience heartburn or stomach pain?
Yes	No	Have you experienced recent weight loss?
Yes	No	Do you have a thyroid condition?
Yes	No	Do you have diabetes?
Yes	No	Do you have low blood sugar?
Yes	No	Do you have a history of cancer?
Yes	No	Have you experienced an increase in frequency of intensity of headaches?
Yes	No	Do you have osteoporosis?
Yes	No	Do you have unusual joint pain and/or swelling?
Yes	No	Do you have a history of fractures?
Yes	No	Do you have impaired vision?
Yes	No	Do you have impaired hearing?

Other Medical Problem:

_____

_____

_____

_____

The purpose of this questionnaire is to assist ABC FOR YOU HEALTH, LLC in providing you quality services by obtaining a better understanding of your total health status. We appreciate your completion of this questionnaire. Should you have any questions or need to share additional information, please discuss with your patient advocate/healthcare liaison. This questionnaire along with all health discussions are considered part of your confidential health record.

Client Signature: _____ Date: _____

Name: _____ Date of Birth: _____/_____/

Name: _____ Date of Birth: _____/_____/_____

Medication List (Please include all prescription and all over the counter - OTC medications)

Medication	Strength	Directions	Prescriber

Drug Allergies

Medication	Reaction	Medication	Reaction

Pharmacy: _____ Phone Number: _____

Client Signature: _____ Date: _____

Name of Primary Care Physician(PCP)/Specialists

Name of Provider	Name of Facility	Type of Specialist	Phone Number

Surgeries

Date	Surgery	Date	Surgery

Hospitalizations

Date of Hospitalization	Reason	Name of Hospital

Client Signature: _____ Date: _____