HEALING GRACE CLINIC
New Patient Intake

Name: _____ **Date of Birth:** _____**Date:** _____

MEDICAL PROBLEMS YOU WOULD LIKE HELP WITH (List):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

OTHER PAST MEDICAL PROBLEMS (List): **SURGERIES (List):**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES (List and include reaction):

_____ _____
_____ _____
_____ _____
_____ _____

CURRENT MEDICATIONS (List):

Name	Dosage	# times/d	Name	Dosage	# times/d

LIFESTYLE/SOCIAL HISTORY:

Tobacco use: No Cigarettes Chew Vapor >100 cigarettes in lifetime?
Alcohol: No Beer/wine Liquor Amt Weekly: _____
Street Drugs: No Type: _____ Amt Weekly: _____
Caffeine: No Coffee Tea Soda Amt Daily: _____
Seat belt use? No Yes **Guns in home?** No Yes
Diet: # Meals daily: _____ **Probs getting food?** Yes
Sexually active? No # Partners in lifetime: 0 1 Greater than 1
If male, history of male partners? No Yes
Feel safe at home? No Yes
If married, how would you rate your marriage? Bad Good Great
Occupation(s): _____**Health risks?** _____

FAMILY HISTORY: **Adopted?** No Yes

Heart Attack	Diabetes	Cancer: Breast: Mom or Sister? Yes
Stroke	Thyroid Disease	Lung
High Blood Pressure	High Cholesterol	Prostate
Other: _____	Other: _____	Other type: _____

PREVENTATIVE CARE HISTORY

Tetanus Shot in past 10 years?	**No**	**Yes**
Pneumonia Vaccine?	**No**	**Yes**
Hepatitis A Vaccine?	**No**	**Yes**
Hepatitis B Vaccine?	**No**	**Yes**
Eye Exam in the past year?	**No**	**Yes**
Dental in the past year?	**No**	**Yes**

For Women Only (if applies):
Last Mammogram date: _____ Normal Abnormal
Last Pap Smear date: _____ Normal Abnormal

REVIEW OF SYSTEMS (Circle any that apply):

General: fever, weight loss, weight gain, fatigue, headache
Skin: rash, change in mole
Eyes: vision changes, redness, drainage, pain
ENT: hearing loss, sinus pain, difficulty swallowing, hoarseness
Allergy: sneezing, itchy/watery eyes, runny nose
Respiratory: cough, wheeze, colored sputum
CV: chest pain, shortness of breath, palpitations, swelling of feet
GI: nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain
GU: frequent urination, pain with urination, losing urine when you do not want to
FOR MEN: urinating more than 2 x at night? No Yes
FOR WOMEN: date last period: _____ Sexually active? No Yes
abnormal bleeding: No Yes
new partner since last pap? No Yes
chance of pregnancy now? No Yes
breast concerns? No Yes
MS: loss of motion, swelling, pain- where? _____
IF PAIN, HOW MUCH DOES IT AFFECT DAILY ACTIVITY Min. Mod. Severe
Neuro: tingling, lack of feeling in extremity, weakness, dizziness, speech problems

----------PLEASE STOP HERE!!----------

WT: _____ HT:_____ T: _____ P: _____ R: _____ BP: _____ Repeat BP: _____
Peak flow: _____ _____ _____ Expected:_____

EXAM:

Gen: A & O, NAD
Skin: No abnormal lesions, rashes
Eyes: PERRLA. EOMi. Non-icteric. No abnl drainage.
HEENT: Atraumatic. TM's/canals clear B. No NC or sinus tend. Lips, teeth, gums, oropharynx WNL
Neck: FROM. No thyromegaly. No tenderness. No adenopathy
Heart: RRR without murmur or gallop. No edema.
Lungs: BS WNL. No wheezes, rales or rhonchi.
Abd: NABS. Percussion WNL. No HSM. No tend./mass/bruit.
MS: FROM. No deformities or discoloration.
Neuro: CN II-XII intact. Strength 5/5 B =. 2+/4+ DTR's B =.
Psych: Cooperative. Mood and affect WNL. Judgment/insight good. No tremor/fidgeting. Memory grossly WNL.

ORDERS:

O CBC with dif O CMP O Hgb A1C O Vit D-OH O TSH w/ Free T4, T3 O U/A rflx mic or cult
O Radiology Study: _____ O Contrast O No contrast
O Dx: _____ O Acute O Chronic
O New Patient Packet (vaccination recommendations, vision/dental resources)
O PT Eval and Tx for _____ x 1 visit (release 6 more once eval received)
O Other: _____

(cont'd)