HC MEDICAL
MC CLINICS

Clinical Intake Form

Date: _____

Patient Name: _____ DOB: _____

Chief Complaint: _____ **Date Onset:** _____

Have you ever been treated for this condition in the past? Yes ☐ No ☐ If yes, please explain _____

_____

_____

Other Concerns: _____

Where were you getting your care before? _____

Marital Status: (circle one) **Married** **Single** **Separated** **Widowed**

If Married: Spouse name _____

How many children? _____**How many grandchildren?**_____

_____

Who lives at home with you?_____

Employed: (circle one) **Yes** **No** **Occupation?** _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things?___No ___Yes

Feeling down, depressed or hopeless? ____No ___Yes

Gender Identity: *Male ☐* *Female ☐*

What sex was originally listed on your birth certificate? *Male ☐ Female ☐ Decline to answer ☐*

Tobacco Use: Yes ☐ No ☐ Former smoker ☐ If yes, how many years? _____ How much? _____
Age Start: _____ Age Stop: _____ Cigs ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐

Alcohol Use: Yes ☐ No ☐ Former alcoholic ☐ Number of drinks per week: _____ Age start: ___ Age Stop: ___
Beer ☐ Wine ☐ Liquor ☐

Recreational Drugs: Yes ☐ No ☐ Have you ever used needles to inject drugs? Yes ☐ No ☐ Age Start: _____
Age Stop: _____ Marijuana ☐ Barbiturates ☐ Amphetamines ☐ Methamphetamine ☐ Opiates ☐ Cocaine ☐

Sexually Active? Yes ☐ No ☐ If yes, what contraceptive (condoms, pill, diaphragm, etc)? _____

Exercise Regularly? Yes ☐ No ☐ How often? _____ How would you rate your diet? Good ☐ Fair ☐ Poor ☐
Uses Seatbelt Regularly? Yes ☐ No ☐ **Hand Dominance?** Right ☐ Left ☐
Current Medications (please list <u>ALL</u> medications including over the counter, inhalers, eye drops, herbs)

Medications	Dosage

Please use the back of the paper if you need to add more medications.

Allergies

No Known Drug Allergies ☐

Medications	*Reaction*	**Food**	*Reaction*	**Environmental**	*Reaction*

Is there anything else you would like us to know? _____

_____

_____

_____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and any collection fees or court costs incurred as a result of my failure to make satisfactory payments. I also authorize Behavioral Health or my insurance company to release any information required to process my claims.

_____ _____

Patient Signature **Date**