



Prism Health recognizes all genders and identities; however, most insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed on your insurance must be used on documents pertaining to insurance and billing. When addressing you, we will use the name and pronouns that you request to assure that we are using the most respectful language.

Please let us know if there's anything we can do to make your time with us more comfortable.

PATIENT REGISTRATION				TODAY'S DATE:	
Legal Last Name:		Legal First:		Middle:	Date of Birth:
Name You Go By:			Social Security Number:		Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex
Pronouns You Use: <input type="checkbox"/> He/His <input type="checkbox"/> She/Hers <input type="checkbox"/> They/Theirs <input type="checkbox"/> Another _____					
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male <input type="checkbox"/> Trans Female <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Gender Non-Conforming <input type="checkbox"/> Non-Binary <input type="checkbox"/> Decline <input type="checkbox"/> Another _____					
Sexual Orientation: <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to say <input type="checkbox"/> Another _____					
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Choose not to say <input type="checkbox"/> Don't know					
Race: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Choose not to say <input type="checkbox"/> Don't know					
Physical Address:		City:	State:	Zip:	Main Phone: OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N
Mailing Address (if different):		City:	State:	Zip:	Other Phone: OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N
Employer:		Occupation:		Full-time <input type="checkbox"/> Part-time <input type="checkbox"/>	Work Phone: OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N
Email address:					
Preferred Written / Spoken Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin <input type="checkbox"/> Russian <input type="checkbox"/> ASL <input type="checkbox"/> Another			Do you need interpretation services? <input type="checkbox"/> N <input type="checkbox"/> Y, language: _____		
Would you like an HIV test at your first appointment? <input type="checkbox"/> Y <input type="checkbox"/> N			Do you have a visual impairment? <input type="checkbox"/> Y <input type="checkbox"/> N		
How did you hear about Prism Health? <input type="checkbox"/> Online/Internet <input type="checkbox"/> Facebook <input type="checkbox"/> Yelp <input type="checkbox"/> A current patient <input type="checkbox"/> Pivot/testing <input type="checkbox"/> Friend/Partner/Family <input type="checkbox"/> Outreach event <input type="checkbox"/> Other: _____					
EMERGENCY CONTACT					
Emergency Contact Name: _____			Relationship: _____		
Phone: _____					
INSURANCE INFORMATION (Note: Co-pays are due at the time of service)					
Insurance Name:		Who is the insurance subscriber? <input type="checkbox"/> Yourself <input type="checkbox"/> Someone else		When did your insurance start? Month: _____ Year: _____	

Patient Name: _____

DOB: _____

Name You Go By: _____

PREVIOUS PROVIDER INFORMATION

Are you transferring your care from another healthcare provider? Y N

If so, please list the name and phone number of your previous provider.
We will also ask you to fill out a Release of Information so we can obtain your medical records.

Name of Provider: _____

Phone Number: _____

MEDICAL HISTORY

Please check ALL that apply:

- | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Asthma
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Cancer
<input type="checkbox"/> COPD | <input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Depression
<input type="checkbox"/> Dental Issues
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dialysis
<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Seizures
<input type="checkbox"/> Sleep Apnea/Snoring
<input type="checkbox"/> Strokes/TIA
<input type="checkbox"/> STD/STI
<input type="checkbox"/> TB
<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Ulcers |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

REVIEW OF SYSTEMS

Please check ALL that apply and have occurred within the last three months, and lasting several days:

BLOOD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Clots	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Bleeding Issues
CARDIOVASCULAR	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Feet/Leg Swelling	<input type="checkbox"/> Fainting	<input type="checkbox"/> Palpitations
GASTROINTESTINAL	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn
GLANDS/HORMONES	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Menopause	<input type="checkbox"/> Menstrual Issues
MENTAL HEALTH	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Suicidal Ideations
MUSCULOSKELETAL	<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Weakness
NEUROLOGICAL	<input type="checkbox"/> Weakness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck/Back Pain	<input type="checkbox"/> Limb Numbness
OB/GYNECOLOGICAL	<input type="checkbox"/> Burning	<input type="checkbox"/> Cramps	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Itching
RENAL	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Urgency/Pain	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Incontinence
RESPIRATORY	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Wet cough
SKIN	<input type="checkbox"/> Bruising	<input type="checkbox"/> Burns	<input type="checkbox"/> Itching/Rash	<input type="checkbox"/> Wounds

MEDICATIONS

List all of your current medications and dosage. Include over-the-counter, vitamins, supplements, CPAP machines, allergy medications, and anything else you take:

Medication Name	Dose	Frequency

Patient Name: _____

DOB: _____

Name You Go By: _____

ALLERGIES

List all medication, and other allergies (food, latex, etc.) you have as well as the reaction (hives, rash, swelling, etc.):

Allergy	Reaction

FAMILY HISTORY

Please list any illnesses, diseases, and/or conditions that any of your immediate family members has had:

Family Member	Illness / Disease / Condition

SURGICAL HISTORY

List all surgeries you have had and the date of the surgery:

Surgery	Date

SOCIAL HISTORY

How many caffeinated beverages do you have per day? _____	What caffeinated beverages do you drink? <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> Energy Drinks <input type="checkbox"/> Other _____
Do you smoke tobacco products? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Used to What do you smoke? _____ How many packs per day? _____ Start date: _____ Quit date: _____	Do you chew tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N Start date: _____ Quit date: _____ Would you like to discuss quitting tobacco products? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N What do you drink? <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	How many drinks per week? _____
Have you used injection drugs? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you shared injection equipment? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you feel unsafe in your current home? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you been a victim of physical or sexual assault? <input type="checkbox"/> Y <input type="checkbox"/> N



Patient Name: _____

DOB: _____

Name You Go By: _____

SOCIAL HISTORY CONTINUED

Over the last two weeks, how often have the following issues applies to you?:

Little interest or pleasure in doing things	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Feeling down, hopeless, depressed	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Feeling tired or having little energy	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Poor appetite or overeating	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Feeling badly about yourself	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Trouble concentrating at work or school	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Moving/speaking slowly, or being fidgety/restless	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
Thoughts of suicide, or hurting yourself	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> Almost every day	<input type="checkbox"/> Every day
If you checked off any of the above problems, how difficult have these problems made it for to do your work, take care of your home, or get along with other people?	<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult			

SEXUAL HEALTH

Are you currently sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N	If no, have you been sexually active in the past? <input type="checkbox"/> Y <input type="checkbox"/> N
Are your sex partners (check all that apply): <input type="checkbox"/> A person with a penis <input type="checkbox"/> A person with a vagina	What body parts do you use when you have sex? <input type="checkbox"/> Penis <input type="checkbox"/> Vagina <input type="checkbox"/> Anus <input type="checkbox"/> Mouth
Has there been any change to your sexual desire? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please describe the change:
Have you had vaginal or anal sex with someone living with HIV? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Not sure	Have you had vaginal or anal sex with someone that uses injection drugs? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Not sure
What method(s) of birth control do you use? <input type="checkbox"/> Condom <input type="checkbox"/> Spermicide <input type="checkbox"/> Dental Dam <input type="checkbox"/> IUD <input type="checkbox"/> NuvaRing <input type="checkbox"/> Depo <input type="checkbox"/> Patch <input type="checkbox"/> Withdrawal <input type="checkbox"/> None <input type="checkbox"/> Another _____	On a scale of 1 – 5, with 1 being never and 5 being always, how often do you use condoms? <input type="checkbox"/> 1 – Never <input type="checkbox"/> 2 – Rarely <input type="checkbox"/> 3 – Half of the time <input type="checkbox"/> 4 – Almost always <input type="checkbox"/> 5 – Always
Please answer this question <i>only</i> if you identify as female: Have you had vaginal or anal sex with someone that has a penis and that person also has sex with people that have a penis? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever exchanged sex for something you need? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an STD/STI? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please check all that apply: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> HPV <input type="checkbox"/> HIV <input type="checkbox"/> Another _____
Have you ever been tested for HIV? <input type="checkbox"/> Y <input type="checkbox"/> N	Would you like to be tested for HIV? <input type="checkbox"/> Y <input type="checkbox"/> N
Are you trying to become pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	Do you have pain during intercourse? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sometimes

Do you have any questions or concerns about your sexual health? Y N
If yes, please explain below:

Patient Name: _____ DOB: _____
Name You Go By: _____

Brief Health Screen

We ask all of our adult patients about substance use and mood because these factors can affect your health. Please ask your provider if you have any questions. Your answers on this form will remain confidential.

Alcohol

One drink = 12 oz. beer / 5 oz. wine / 1.5 oz. liquor (one shot)

1. If you were male at birth: How many times in the past year have you had 5 or more drinks in a day?
 None 1 or more

2. If you were female at birth: How many times in the past year have you had 4 or more drinks in a day?
None 1 or more

Drugs

Recreational drugs include methamphetamines (speed, crystal, etc.), marijuana, inhalants (glue, aerosol, etc.), tranquilizers (Valium, Xanax, etc.), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms, etc.), or narcotic (heroin, Oxycodone, etc.).

1. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?
 None 1 or more

Mood

1. During the past two weeks, have you been bothered by little interest or pleasure in doing things?
 None 1 or more

2. During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?
 None 1 or more



Patient Name: _____

DOB: _____

Name You Go By: _____

OTHER

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

Please read this following carefully and sign below:

I certify that the information I have given on my patient intake form is correct and complete to the best of my knowledge. I acknowledge that keeping any health information from my provider may hinder them from being able to give me adequate patient care. It is my responsibility to keep my provider informed of any new health issues that may arise.

Patient Signature

Date