



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

Please let us know if there is anything we can do to make your time with us more comfortable. Thank you.

PATIENT REGISTRATION		TODAY'S DATE:	
Name on file with your insurance Last: _____ 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"/> Other _____			
Gender Identity: <input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Transgender <input type="checkbox"/> Cisgender <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Gender Non-Conforming <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> Decline <input type="checkbox"/> Another _____			
Sexual Orientation: <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Asexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Straight <input type="checkbox"/> Questioning <input type="checkbox"/> Decline <input type="checkbox"/> Another _____			
Relationship Structure: <input type="checkbox"/> Single <input type="checkbox"/> Monogamous <input type="checkbox"/> Polyamorous <input type="checkbox"/> Open/Non-Monogamous <input type="checkbox"/> Aromantic <input type="checkbox"/> Kink/BDSM <input type="checkbox"/> Questioning <input type="checkbox"/> Decline <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 <input type="checkbox"/> Another _____			
Physical Address: City: _____ State: _____			
Main Phone: _____ OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N		Work Phone: _____ OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N	Other Phone: _____ OK to leave voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N
Email address: _____		<input type="checkbox"/> N	
Employer: Occupation: _____ Full-time <input type="checkbox"/> Part-time <input type="checkbox"/>			
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"/> Other _____		Do you need interpretation services? <input type="checkbox"/> N <input type="checkbox"/> Y, language: _____ 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: _____			



Please note: All patients are asked to provide the below information in order to determine if you might be eligible for discounted fees or services.

What is your current annual income? \$ \_\_\_\_\_  Decline to Answer

How many people are in your household? \_\_\_\_\_  Decline to Answer

Are you a US Veteran?  Y  N

**EMERGENCY INFORMATION**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE INFORMATION (Note: Co-pays are due at the time of service)**

Insurance Name and ID Number:	Who is the insurance subscriber? <input type="checkbox"/> Yourself <input type="checkbox"/> Someone else	When did your insurance start? Month:            Year:
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**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
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**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: \_\_\_\_\_



<b>ALLERGIES</b>	
List all medication, and other allergies (food, latex, etc.) you have as well as the reaction (hives, rash, swelling, etc.):	
Allergy	Reaction
<b>FAMILY HISTORY</b>	
Please list any illnesses, diseases, and/or conditions that any of your immediate family members has had:	
Family Member	Illness / Disease / Condition
<b>SURGICAL HISTORY</b>	
List all surgeries you have had and the date of the surgery:	
Surgery	Date
<b>SOCIAL HISTORY</b>	
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: \_\_\_\_\_



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"/> <del>None</del> <input type="checkbox"/> Another _____	On a scale of 1 – 5, with 1 being never and 5 being always, how often do you use condoms? ┆ 1 – Never <input type="checkbox"/> 2 – Rarely <input type="checkbox"/> 3 – Half of the time ┆ 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? ┆ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yea, please explain:	

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**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.

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**Alcohol**

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

1. If you were assigned 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 assigned 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: \_\_\_\_\_

**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