

Personal Data

Thank you for allowing us to participate in your healthcare! Please take a few moments to complete this form. Your healthcare provider will review this information during your visit. Filling out all sections will help us to better serve your health care needs.

Patient's Name: _____ **Date of Birth:** _____ **Chart/Acct #** _____

Preferred language spoken? English Spanish Other _____ Last grade of education completed _____

Are there any issues that may interfere with your appointments or medical care? Cost Memory Transportation

How can your healthcare provider best assist with your learning needs relative to your care?

Audio/Video Written Material Discussion with your healthcare provider or nurse

Yes No Do you depend on people living with you for personal care? If yes, what type of care? (Ex: bathing, dressing, mobility, etc.) _____

Yes No Have you fallen in the last 12 months or do you have concerns regarding falls or home safety? If yes, please explain: _____

Yes No Are there any cultural or religious beliefs that your health care provider should be aware of that would be helpful in your health care? If yes, please explain: _____

Yes No Do you have any nutritional restrictions, needs or concerns? If yes, please list them: _____

Yes No Have you been treated for pain in the past six (6) months to one (1) year? If yes, please explain what pain you were treated for (such as headache, back pain, etc.). _____
Which method seems to work the best for your pain? _____

Yes No Do you have any history of mental, emotional, behavioral problems or depression? If yes, explain briefly: _____

Yes No Would you like information on advance directives? If you have an advanced directive (Living Will, Healthcare Power of Attorney, Advanced Instruction for Mental Health Treatment, Organ Donor Card), please provide a copy to be placed in your medical record.

Yes No Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If so, by whom? _____

Yes No Do you have concerns about your safety in your current relationship/environment?

Yes No Is there a partner from a previous relationship who is making you feel unsafe now?

Patient Signature: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted _____ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

To be reviewed by provider once a year or when changes occur

Reviewed by: _____ Initials / Date _____ Initials / Date _____

Reviewed by: _____ Initials / Date _____ Initials / Date _____

Reviewed by: _____ Initials / Date _____ Initials / Date _____



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