NP Walk-In Clinic
www.npclinictn.com
615.306.9996
Lavonne Clifford, MSN, ARNP, FNP-C, CEN

Patient Intake Form

First_____ M.I._____ Last_____

Sex: Male / Female Date of Birth_____/_____/_____

Address_____

City_____ State_____ Zip Code_____

Cell Phone (_____)_____-_____

Email_____

How did you hear about us? _____

EMERGENCY CONTACT

Contact_____

Relationship_____ Cell Phone_____

ALLERGIES? If yes, please list all known allergies to medications or substances.

YES, I have the following allergies _____

NO known allergies.

HEALTH HABITS Please circle all that apply.

Caffeine use…… occasional often never
Drink Alcohol……occasional often never
Exercise…… occasional often never
Drink Water…… <64 oz/day >64 oz/day never
Cigarettes…… <1 pack/day >1 pack/day never
Sleep…… <8 hours/night >=8 hours/night Insomnia Other

_____

NP Walk-In Clinic
www.npclinictn.com
615.306.9996
Lavonne Clifford, MSN, ARNP, FNP-C, CEN

Health Summary

FAMILY HISTORY Please circle all that apply and list relative type.

Arthritis:_____ Thyroid:_____
Cancer:_____ Stroke:_____
Diabetes:_____ Hypertension:_____
Heart Disease:_____ Other:_____

CONDITIONS Please circle conditions you currently have or have had in the past.

AIDS
Alcoholism
Anemia
Anorexia
Anxiety
Arthritis
Asthma
Bleeding disorder Breast lump
Bronchitis
Bulimia
CAD/Heart disease Cancer, type_____ Chemical dependency Depression
Diabetes
Emphysema/COPD
Epilepsy
GERD (reflux)
Glaucoma
Goiter
Gout
Headaches
Heart attack Hepatitis
Herpes
High blood pressure
HIV positive
Kidney disease Liver disease Multiple sclerosis
Pacemaker
Pneumonia
Prostate problem
Psychiatric care
Rheumatic fever
Rhinitis
Sexually transmitted infection Stroke
Suicide attempt
Thyroid Problem
Tuberculosis
Ulcer(s)
Vaginal Infections

HEALTH MAINTENANCE Please list the most recent date for each of the following:

WOMEN ONLY

Menstrual period_____
Mammogram_____
Pap Smear_____

BOTH MEN AND WOMEN

General physical_____
Cholesterol testing_____
Colonoscopy_____
Tetanus booster_____
Bone Density (DEXA)_____
Pneumonia vaccine_____

MEN ONLY

Digital rectal exam_____
PSA (Prostate blood test)_____

WOMEN: Are you. . .
Pregnant/Trying to become pregnant? Y / N Taking oral contraceptive? Y / N Nursing? Y / N

NP Walk-In Clinic
www.npclinictn.com
615.306.9996
Lavonne Clifford, MSN, ARNP, FNP-C, CEN

Health Summary Continued...

SURGICAL HISTORY Please list all surgeries you have had in the past.

Date Type of Surgery

_____
_____
_____
_____
_____
_____

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES Please list below. Date Reason for hospitalization, nature of illness, or injury

_____
_____
_____
_____

MEDICATIONS List all medications including the dose and frequency.

_____
_____
_____
_____
_____
_____
_____
_____

Release of Consent & Liability

YES, I give permission to discuss my medical condition(s), my treatment to the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

NO, the staff may not divulge information regarding my medical treatment or medical care to anyone other than me.

My signature below indicates that I have been given the opportunity to review a current coly of the Encompass Health, LLC “Notice of Privacy Practices”.

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or co-pay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Patient or legally authorized signature_____ Date_____

Relationship to the patient_____