JD Health and Wellness Center Intake

608 Lancaster Drive SE Salem, OR 97317 503-877-1995 P. 888-990-1352 F.

Name:

_____

First Middle Last

Maiden name:_____

Marital Status: ☐ Married ☐ Single never married ☐ Single, divorced ☐ Married separated ☐ Widowed

☐ Living as married ☐ other: _____

AKA's: _____

D.O.B ___/___/_____ **Social Security Number**: ____-_____-_____

Address: _____

_____

Home Phone# ( ) _____ **Cell Phone** ( ) _____

Gender: ( ) Male ( ) Female ( ) N/A **Female, Are you pregnant?** ( ) Yes ( ) No

Are you a veteran ( ) Yes ( ) No

Race: _____ **Height**: ____' ____" **Weight**: _____ lbs.

Hair Color: _____ **Eye Color**: _____

Highest Grade Level Completed: _____ **Vocational Program(s) Completed**: _____

Have you ever been homeless? ( ) Yes ( ) No

Are you currently enrolled in school? ( ) Yes ( ) No

Are you currently employed? ( ) Yes ( ) No

If no, are you currently seeking work? ( ) Yes ( ) No

If yes, how much do you work? ( ) More than 35 hours per week

( ) 17-34 hours per week

( ) Less than 17 hours per week

Gross Monthly Income: $ _____ (includes you and anyone you live with)

Employment: _____ **Job title:** _____

List the name and age of people dependent upon that income:

_____

Personal Medical History: _____

_____

_____

Family Medical History: _____

_____

_____

Surgeries: _____

_____

Primary Source of Household Income: ( ) Wages/Salary ( ) Social Security ( ) SSI-Federal ( ) OSIP-State ( ) Public Assistance ( ) Dividends/interest ( ) Pension/Unemployment/Veterans

Employability Factor: ( ) Employable or Working now ( ) Student ( ) Homemaker ( ) Retired ( ) Unable for physical or Psychological reasons ( ) Seasonal Worker ( ) Temporary Layoff

Health Insurance Coverage: ( ) Oregon Health Plan ( ) Medicare ( ) Medicaid ( ) V. A ( ) Private: _____ ( ) Public _____ __ ( ) None

Marital Status: ( ) Married ( ) Single, divorced ( ) Married, separated ( ) Widowed ( ) Living as married ( ) Other: _____

Living Arrangement: ( ) In my own home ( ) Parent/relative or adult children's home ( ) Foster Home ( ) Institution or group home ( ) Friend's home ( ) Homeless/shelter

Primary Insurance to be billed: _____

Phone #: ( ) _____ Group#:_____ ID#: _____

Secondary Insurance to be billed: _____

Phone #: ( ) _____ Group#:_____ ID#: _____

Secondary Insured Name: _____ **D.O.B** _____/_____/_____

BY LAW WE MUST HAVE AN EMERGENCY CONTACT

Person to notify in case of an emergency: _____

Relationship: _____

Address: _____

Telephone # ( ) _____

Can we leave Voicemail with emergency contact ( ) Yes ( ) No

Is there anyone you would like to authorize to schedule/cancel appointments for you ( ) Yes ( ) No

If yes, who? Name: _____ **DOB:** _____

Can we discuss your medical treatment with this person? ( ) Yes ( ) No

Is this person authorized to pay benefits ( ) Yes ( ) No

_____ _____

Patient Signature Date

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Financial Agreement and Consent to Treat

I hereby assign JD Health and Wellness all payments to which I am entitled for expenses related to the services performed and direct that payment for such services to be made to JD Health and Wellness. I authorize JD Health and Wellness to release such information as may be required to secure such payment. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original. I consent to medical/rehabilitative services performed by JD Health and Wellness Center.

_____ _____

Patient Signature **Date**

_____ _____

Staff Signature **Date**

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Adult Health History for New Patients

Your answers on this form will help your health care providers get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update from you can use. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you.

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

Medications: Please list all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

( ) **TAKE NO MEDICATIONS**

Medication	**Dose (e.g. mg/pill)**	**how many times per day**

Allergies or intolerance to medications (include type of reaction):

_____

_____