Rev 12.4.2018

DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.
alleghenymedical.com

PATIENT INTAKE FORM

Full Legal Name: _____ /_____ /_____
Last Name *First Name* *Middle Initial*

Age: _____ **Date of Birth**: _____ /_____ /_____ **S.S. #:** _____-_____-_____

Address:_____ **City:** _____ **State:** ___ **Zip**: _____

(H) Phone # (____)_____ **Mobile #** (____)_____ (circle one) **Best # to reach you H or M**

E-mail address: _____ **Gender**: Female ☐ (Pregnant? ☐) Male ☐

Single ☐ **Married** ☐ **Other** ☐ **Spouse or Partner Name:** _____

Employer / School: _____ **Phone#** (_____)_____

Address: _____ **City:** _____ **State:** ___ **Zip**: _____

Occupation: _____ circle which applies: **(Full time/ Part time /Student/ Retired)**

Emergency Contact
Name: _____ **Relationship:** _____ Phone#(_____)_____

Other than yourself, to whom may we disclose your Protected Health Information?_____

Provide your PCP and current pharmacy information: (if no PCP, please put **N/A** in "Family MD" area)

Family MD _____ **Phone #** _____

Pharmacy _____ **Phone #** _____

How did you hear about us? **(Please check all that applies)** TV Billboard Radio Internet OTHER_____

If referred by our patient, please print their name(s):_____

Is there any place you do NOT want us to leave a message? _____

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO FRONT DESK FOR SCANNING/COPYING

HEALTH INSURANCE INFORMATION

Do you have medical insurance? Yes ☐ No ☐
Do you have Medicare? Yes ☐ No ☐
Insurance Company Name _____
Insurance Company #_____
Type of Insurance: HMO ◯ PPO ◯ POS ◯ OTHER ◉
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

Do have any other insurance? Yes ☐ No ☐
If Yes, complete below;
Insurance Company Name _____
Insurance Company Phone_____
Type of Insurance:HMO ◯ PPO ◉ POS ◯ OTHER ◯
Policy#_____ Group#_____
Policy Holders Name _____
Their DOB:_____ Relationship _____

What are the concerns for which you are seeking care today? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

Medications and Supplements

What medications (prescribed or over the counter) are you currently taking? Including Vitamins?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any known contagious diseases at this time? Yes ☐ (Explain)_____ or **No** ☐

Please check if you presently or have ever had any of the following symptoms.

Checklist Self Review

GENERAL
- Fatigue ☐
- Fever/Chills ☐
- Weakness ☐
- Weight Loss ☐
- Trouble Sleeping ☐

EARS
- Hearing Loss ☐
- Earache ☐
- Discharge ☐
- Ringing ☐

THROAT
- Soreness ☐
- Swallowing ☐
- Infections ☐
- Dryness ☐
- Color Changes ☐
- Sores/Lumps ☐

CHEST
- Short Breath ☐
- Cough ☐
- Chest Pain ☐
- Wheezing ☐

HEART
- Cold Extremity ☐
- Ankle Edema ☐
- Murmur ☐
- Varicosity ☐
- Blood Clots ☐
- Palpitations ☐

GENITOURIN
- Urine Hesitancy ☐
- Incontinence ☐
- Urgency ☐
- Frequency ☐
- Kidney Stones ☐

WOMAN
- Painful Sex ☐
- Discharge ☐
- Irregular Periods ☐
- Hot Flashes ☐
- Loss of Libido ☐
- Dryness ☐
- STD ☐
- Last Period_____

EYES
- Blurry ☐
- Double ☐
- Pain ☐
- Redness ☐
- Change in Vision ☐
- Flashing light/Specks ☐
- Glasses or Contacts ☐
- Cataracts ☐
- Glaucoma ☐
- Last eye exam _____

NOSE
- Bleeding ☐
- Discharge ☐
- Obstruction ☐

HEAD
- Headaches ☐
- Injuries ☐
- Dizziness ☐

MOUTH
- Bad breath ☐
- Bleeding Gums ☐
- Ulcers/ Sores ☐
- Dental Problem ☐
- Loss of Taste ☐
- Sore Tongue ☐
- Dry Mouth ☐

BREASTS
- Lumps ☐
- Pain ☐
- Discharge ☐
- Breast Feeding ☐

MUSCULOSKELETAL
- Muscle or joint pain ☐
- Stiffness ☐
- Muscle Weakness ☐
- Back Pain ☐
- Swelling of joints ☐
- Redness of Joints ☐
- Trauma ☐

NECK
- Pain ☐
- Stiffness ☐
- Swollen Glands ☐
- Swallowing Difficulties ☐

MAN
- Painful sex ☐
- Hernia ☐
- Discharge ☐
- Erectile Dysfunction ☐
- Pain or Masses ☐
- STD ☐

ENDOCRINE
- Heat or Cold Intolerances ☐
- Excessive Thirst ☐
- Excessive Sweating ☐
- Trouble Sleeping ☐

NEUROLOGICAL
- Dizziness ☐
- Fainting ☐
- Seizures ☐
- Weakness ☐
- Numbness ☐
- Tingling ☐
- Tremor ☐

RESPIRATORY
- Cough (dry or wet) ☐
- Sputum (color & amount) ☐
- Coughing up blood ☐
- Shortness of Breath ☐
- Wheezing ☐
- Painful Breathing ☐

PSYCHIATRIC
- Nervousness ☐
- Memory loss ☐
- Stress ☐
- Depression ☐
- Anxiety ☐

GASTRIONTESTINAL
- Nausea ☐
- Black Stool ☐
- Vomiting ☐
- Jaundice ☐
- Diarrhea ☐
- Constipation ☐
- Bloody Stool ☐
- Heartburn ☐
- Hemorrhoids ☐
- Belching ☐
- Abdominal Pain ☐

CARDIOVASCULAR
- Tightness ☐
- Palpitations ☐
- Swelling ☐
- Difficulty lying down ☐
- Shortness of breath (rest) ☐
- Shortness of breath (activity) ☐
- Chest Pain ☐

VASCULAR
- Calf pain when walking ☐
- Leg cramping ☐
- Swelling of leg ☐

HEMATOLOGICAL
- Ease of bruising ☐
- Ease of bleeding ☐

If yes to any symptoms, Please indicate if you are currently or in the past have experienced them:

Family History Please write appropriate letter to describe: E - Excellent G-Good F-Fair P-Poor

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
*Current Health							
Age at death							
Cause of death							

Please mark the number of family members on appropriate line:

Please indicate if there have been any of the following diseases in you, your parents, grandparents, siblings, or children.

*Cancer ☐ Diabetes ☐ Epilepsy ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Anemia ☐ Kidney ☐ Disease ☐ Glaucoma ☐ Allergies ☐ Asthma ☐ Mental Illness ☐ Arthritis ☐ Tuberculosis ☐ Alzheimer's ☐ HIV ☐ Hepatitis ☐ Joint Replacement ☐ Bypass ☐ Heart Attack ☐

***Please Specify** _____

Have you had any surgeries? If so, please list:_____

Food, drug, or latex allergies? If so, please list:_____

Tobacco? ☐ YES ☐ NO **How Often?**_____ **How Long?**_____

Alcohol? ☐ YES ☐ NO **If Yes, Type?**_____ **How Often?**_____

Caffeinated beverages? ☐ YES ☐ NO **If Yes, Type?**_____ **How Often?**_____

Street Drugs ☐ YES ☐ NO **If yes, please discuss with doctor**

Complete Care Check Based on health standards guidelines, you should be checked for the following.

Question	YES	NO	Pt. Response	Recommendation
Last Annual checkup?	☐	☐		
Do you have a primary care doc?	☐	☐		
Do you suffer from allergies?	☐	☐		
Do you suffer from fatigue?	☐	☐		
Do you wake up w/ pain or aches?	☐	☐		
Have you ever had any back or joint pain?	☐	☐		
Have you been screened for any suspicious spots, moles, lesions, or skin tags?	☐	☐		
Any family member been treated for any cancer?	☐	☐		
Have you smoked in the past?	☐	☐		
Have you had your (BMI Test) height and weight ratio test?	☐	☐		
Do you suffer from weight gain or loss?	☐	☐		
Do you suffer from mood swings?	☐	☐		
Do you feel stressed or feel it's too much to handle?	☐	☐		
Have you ever noticed a racing mind, fogginess, daydream, or forgetful?	☐	☐		
Do you find yourself limiting or avoiding activities due to how you feel?	☐	☐		
Have you had a Lyme test?	☐	☐		
Have you had a hearing test?	☐	☐		
Have you had a vision test?	☐	☐		
Have you had your flu vaccine?	☐	☐		

The patient or legal guardian must sign authorizations, such as in the case of a minor or when the patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

Consent for Treatment

The signature below authorizes consent to have your picture taken for the sole purpose of **identification.** This material **will not be sold** or **distributed for any reason**.

The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer such procedures and treatment as deemed necessary, or as required by my employer. There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

Assignment of Benefits

I _____ authorize Allegheny Medical, P.C. to be paid directly for services rendered. I accept responsibility for any service(s) that may not be covered by my health insurance, automobile insurance, or workers compensation carrier. I further authorize Allegheny Medical, P.C. to furnish information concerning my present illness or injury which may contact alcohol, drug, HIV or psychiatric related history to the insurer and health care providers involved in my care. I further direct the insurer to pay without equivocation directly to Allegheny Medical, P.C. any and all benefits due as a result of treatment and service(s) provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier. I hearby state and agree that a photocopy of this document will be deemed as valid and bindings on all parties involved as the original copy.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

Medicare Assignment of Benefits

In accordance with the Medicare Act, Section 1842 (I) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (II) (A) of the Medicare act. If Medicare determines that a particular service(s), although normally covered is not reasonable and necessary because the service(s) is maintenance in nature as defined by Medicare policy, Medicare will deny payment for those service(s). Medicare is likely to deny payment for service(s) that lack medical necessity. By my signature, I acknowledge notification by Allegheny Medical, P.C. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient _____ Date:_____

Signature of Guardian_____ Date:_____

NAME:

DOB

DATE:

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feelings that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions.

Select one of the five responses for each of the fourteen questions.

0= Not Present **1= Mild** **2=Moderate** **3= Severe** **4=Very Severe**

☐ Anxious mood	Worries, anticipation of the worst, fearful anticipation, irritability.
☐ Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.
☐ Fears	Of dark, of strangers, of being left alone, of animals, of traffic or crowds.
☐ Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.
☐ Behavior at interview	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, signing or rapid respiration, facial pallor, swallowing, etc.
☐ Intellectual	Difficulty in concentration, poor memory.
☐ Depressed mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.
☐ Somatic(muscular)	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.
☐ Somatic(sensory)	Tinnitus, blurring of vision, hot and cold flushes, feeling of weakness, pricking sensation.
☐ Cardiovascular symptoms	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beats.
☐ Respiratory Symptoms Gas	Pressure or constriction in chest, choking feelings, sighing, dyspnea.
☐ ɔintestinal symptoms	Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness nausea, vomiting, borborygmic, looseness of bowels, loss of weight constipation.
☐ Genitourinary symptoms	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.
☐ Autonomic symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tensions headache raising of hair.

Reviewed by: Date:

Comments:

NAME:_____ DOB:_____ DATE:_____

STOP BANG Questionnaire

Height_ Inches /cm Weight ___ Lb/kg
Age ___
Male ◯ Female ◯
BMI
Collar size of shirt: SELECT - _____ Inches/cm
Neck circumference*_____cm

1. Snoring
Do you snore loudly (louder limn talking or loud enough to be heard through closed doors)?
Yes ◯ No ◯

2. Tired
Do you often feel tired, fatigued, or sleepy during daytime?
Yes ◯ No ◯

3. Observed
Has anyone observed you stop breathing during your sleep?
Yes ◯ No ◯

4. Blood pressure
Do you have or are you being treated for high blood pressure?
Yes ◯ No ◯

5. BMI
BMI more than 35 kg/ni2?
Yes ◯ No ◯

6. Age
Age over 50 yr old?
Yes ◯ No ◯

7. Neck circumference
Neck circumference greater than 40 cm? Yes ◯ No ◯

8. Gender male?
Yes ◯ No ◯

* Neck circumference is measured by staff
High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from: ***STOP*** *Questionnaire*

NAME_____

DOB_____

DAT E _____

ALLEGHENY MEDICAL

PHQ-9 depression questionnaire

Over the last two weeks, how often have you been bothered by any of t:he following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little Interest or pleasure In doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or slaying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could *have* noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total_____=		+ ____	+ ____	+

PHQ-9 score 2: 10; Likely major depression

Depression score ranges:

5 to 9 : mild

10 to 14: moderate

15 o 19: moderately severe

>20: severe

If you checked off any problems, how difficult have these problems made It for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
	☐	☐	☐	

PHQ: Patient Health Questionnaire