Equal Access Clinic Network

Patient #

Intake Assessment Form **Volunteer Initials: _____** *version 1-11-2016*

Basic Info

Last Name	**First Name**		**Have You Been to Equal Access or the Mobile Clinic Before?** Yes No
Date of Birth:	**Clinic Location:**	**Date of Current Visit:**	
Reason for Visit (Chief Complaint):			**How Did You Hear About Us?**

Patient Information

Sex at Birth: Female Male	**Gender:** Man Woman Transgender/Transsexual Other/Don't Know Would rather not say	**Veteran:** Yes No	**Primary Language:** English Other _____
Race/Ethnicity: White Black/African American Hispanic/Latino Indian Asian Pacific Islander Other _____	**Marital Status:** Single (Never married) Married Separated Divorced Widowed	**Current Housing/ Shelter:** *# in Household Including Pt?* _____ *Type of Housing:* Apartment/ House Friend/ Relative Hotel/Motel Halfway House Drug Rehab Street/Car Homeless Shelter *How long homeless?* _____	

Patient's Street Address **Apt. No.**	**City**	**State**	**Zip Code**

Email (if patient has one):

(Read the following) "We have a follow-up program to help patients get services and resources to improve their health and lives. We will help with anything you might need, particularly anything that the doctor recommends at this visit such as visits to other clinics, medications or lifestyle changes."

What is the best number to reach you at so that we can follow-up? ( ) ☐ Patient refused **Is there another phone number we could reach you at? ( )** ☐ No	**When is the best time to call?** Morning Afternoon Evening Other_____	**When are the best days to call?**

US Citizen: Yes No	**Highest Level of Education:** None, 6th – 8th Grade, 9th-11th Grade, High School Grad/GED, Vocational School, Some College, Associates Degree (AA), Bachelor's Degree, Graduate School

Employment Status: Not Employed (Not a Student) Full Time Part Time Retired Student	**Patient's Occupation (if applicable):**	**How did you get to Clinic?** I drove myself I got a ride from somebody else I walked I rode a bike I took a bus Other _____

Insurance & Housing

Medical Insurance:
- None
- Medicaid
- Medicare
- Private insurance
- VA benefits

Do you feel safe in your current living situation?
- Yes
- No → Notify Healthcare Provider

Screening Questions

Are you younger than 50 years old?
- Yes
- No

Have you had a colonoscopy in the last 10 years?
- Yes
- No

(If both answers are no) **If offered, would you be interested in a free colorectal screening?**
- Yes → Notify Healthcare Provider
- No

Do you currently smoke?
- Yes
- No

(If yes) **Are you interested in help with quitting?**
- Yes → Notify Healthcare Provider
- No

Do you have pain or problems with movement due to injury, overuse or health issues?
- Yes
- No

(If yes) **Are you interested in free physical therapy?**
- Yes → Notify Healthcare Provider
- No

Have you been tested for HIV in the last 6 months?
- Yes
- No

(If no) **Are you interested in receiving a free HIV test?**
- Yes → Perform or notify Healthcare Provider
- No

Do you drink alcohol?
- Yes
- No → Skip this section

How many drinks per week?

** If the patient is male and drinks more than 14 drinks per week notify healthcare provider*
** If patient is female and drinks more than 7 drinks per week notify healthcare provider*

During the past month, have you often been bothered by feeling little interest or pleasure in doing things?
- Yes
- No

Have you often felt down, depressed, or hopeless?
- Yes
- No

During the past month, have you frequently been bothered by feeling worried or anxious most of the time?
- Yes
- No

Have you had an anxiety attack suddenly feeling fear or panic?
- Yes
- No

**If the patient answers yes to any of these 4 questions, inform the healthcare provider*

Have you ever had a partner try to control you?	Yes	No	** If yes to any of the 3, notify healthcare provider*
Have you ever had a partner that you were afraid of?	Yes	No	
Have you ever had a partner who has threatened you?	Yes	No	

* For male patients, skip the Women's Health Screening

Women's Health

Do you see a gynecologist regularly?
- Yes
- No

Have you gotten a PAP smear in the last year?
- Yes
- No

Is patient outside the range of 50-64 years old?
- Yes
- No

Have you had a mammogram in the last 2 years?
- Yes
- No

Medication Screening

How many medications are you currently taking? _____

** If the answer is more than 3 and you are at a clinic with on-site pharmacy, tell the pharmacist/pharmacy students as soon as you finish the intake that your patient needs to have a medication history performed*

Past Medical History Screening *(For Triage only, NOT a full past medical history)*

Have you ever been told by a healthcare provider that you have one of the following? *(Circle all that apply)*

Anxiety
Arthritis
Asthma
Bipolar Disorder
Chest Pain
Depression
Diabetes
Headaches
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
HIV/Aids
Kidney Disease
Post-Traumatic Stress Disorder (PTSD)
Schizophrenia
Seizure
Sexually Transmitted Disease (STDs)
Stroke
Other _____

Patient Satisfaction

Have you been hospitalized in the past 30 days? **Yes** **No**

If the clinic did NOT exist how likely would you be to go to the Emergency Room for your current health issue?
Very likely Somewhat Likely Neutral Very unlikely Does not apply

Have you made fewer visits to the Emergency Room in the last 6 months because of this clinic?
Yes No N/A

Have you ever had to go to the Emergency Room because you could not be seen by another doctor or clinic?
Yes No N/A

Vitals

Weight	**Height**	**BMI**	**Temp**
BP	**Pulse**	**O2 Sat**	**Respirations**

First and Last Names of Student you handed off to: _____
Attending Physician: _____

Check the appropriate box after the data has been entered:
____ This information has been entered into Practice Fusion
____ This information has been Entered into Red Cap

If you have any questions, comments or suggested improvements for this form please contact Austin Reed at acreed@ufl.edu