Legacy
Community Health Services

ADULT CLIENT INTAKE FORM

Date: _____ **Chart #:** _____ **Age:** _____

Legacy Community Health Services is a Community Health Center and all information requested is for statistical purposes. All information is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent. The information requested allows Legacy to evaluate each client for eligibility for our programs; therefore, we request you complete this document in its entirety.

NAME	PREFERRED NAME (IF APPLICABLE)

ADDRESS	CITY / STATE	ZIP CODE	COUNTY

MAIN PHONE NUMBER	OTHER PHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH
		☐ N/A	

PREFERRED METHOD(S) OF CONTACT

Telephone: ☐ Yes ☐ No [Okay to leave a message: ☐ Yes ☐ No] | Mail: ☐ Yes ☐ No | ☐ No Contact

MARITAL STATUS	SEXUAL ORIENTATION
☐ Single ☐ Married ☐ Living with Domestic Partner ☐ Divorced ☐ Other _____	☐ Heterosexual ☐ Homosexual ☐ Bisexual

GENDER	TRANSGENDER	SOCIAL SECURITY	BIRTH STATE/COUNTRY	DRIVER'S LICENSE #
☐ Male ☐ Female	☐ Yes ☐ No			

PREFERRED LANGUAGE	RACE
☐ English ☐ Spanish ☐ Other _____	☐ White ☐ Black/African American ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ Hawaiian ☐ Other ☐ Am. Indian/Alaska Native ☐ Unknown/Decline to Report

ETHNICITY	HOMELESS	AGRICULTURE WORKER	US MILITARY VETERAN
☐ Hispanic ☐ Non-Hispanic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

FAMILY SIZE (# OF PERSONS LIVING IN YOUR HOME)	TOTAL FAMILY HOUSEHOLD INCOME

Please provide your emergency contact information below.

NAME	RELATIONSHIP	PHONE NUMBER	ADDRESS
Does this person know that you are a patient of Legacy Community Health Services? ☐ Yes ☐ No			

Primary Caregiver

(Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided.)

☐ N/A, I do not have a primary caregiver ☐ Same as emergency contact	NAME	RELATIONSHIP	PHONE NUMBER

Legal Guardian

(Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided.)

☐ N/A, I do not have a Legal Guardian ☐ Same as emergency contact	NAME	RELATIONSHIP	PHONE NUMBER

Name: _____

Health Care Proxy

(Person patient appoints to make healthcare decisions in their place. Appropriate documentation must be provided.)

☐ N/A, I do not have a Health Care Proxy ☐ Same as emergency contact	**NAME**	**RELATIONSHIP**	**PHONE NUMBER**

Medical Information

NAME OF PRIMARY CARE PROVIDER	**ADDRESS**	**PHONE NUMBER**
NAME OF PREFERRED PHARMACY	**ADDRESS**	**PHONE NUMBER**

DO YOU HAVE ANY ADVANCED DIRECTIVES?

☐ No ☐ Yes ☐ Do Not Resuscitate ☐ Medical Power of Attorney ☐ Living Will

MATERNITY PATIENTS ONLY

☐ N/A

For your current pregnancy, in what month of your pregnancy did you first receive care? _____

Did you receive this care from Legacy? ☐ Yes ☐ No

Complete the insurance questions below.

DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE MEDICAID, MEDICARE, CHIP, V.A., OR OTHER INSURANCE COVERAGE?

☐ Yes ☐ No **If yes, who?** _____

WHAT TYPE OF HEALTH INSURANCE DO YOU HAVE?

☐ None / Self Pay ☐ Military ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance

Plan #: _____ Group#: _____

Private Insurance Company: _____

PCP Provider if HMO Policy: _____

INSURED/POLICY HOLDER'S INFORMATION	**INSURED EMPLOYER'S INFORMATION**
Name: _____	Name: _____
Date of Birth: ____/____/____	Address: _____
Social Security #: ____ - ____ - ____	_____
	Phone: (____) ____ - ____

Marketing

HOW DID YOU LEARN ABOUT OUR SERVICES?

☐ Friend/Relative ☐ In Print ☐ On Radio/TV ☐ Internet ☐ Referral ☐ Community Event ☐ Other

By signing this form, I attest that all the statements I have made, including my answers to all questions are true and correct to the best of my knowledge and belief. I agree to give the eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment. Should my income or number of people in my family change, I will tell the eligibility staff.

_____ _____

Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____

Signature of Person Who Helped Complete this Form Date

Legacy
Community Health Services

ADULT
CONSENT & ACKNOWLEDGMENT
FOR SERVICES

Name: _____

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, in order to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety. You have the privilege of revoking this consent, by providing written notice, at any time.

CONSENT FOR TESTING AND TREATMENT

By initialing, I hereby grant permission to Legacy Community Health Services to perform such tests, treatments and procedures as ordered by the medical staff for diagnostic and/or therapeutic purposes, including, but not limited to, STD testing including but not limited to HIV. As part of the testing and treatment I may receive disease-specific prevention, education, and risk-reduction services. Legacy Community Health Services is required by state law to report my name, address, treatment and other information to the City of Houston Department of Health & Human Services for known persons who test positive for TB, HIV/AIDS, and syphilis. Persons who test positive may be contacted by a Disease Intervention Specialist (DIS) to ensure they have been successfully treated and that sex partners who may be at risk for the disease have been notified about their potential risk.

_____ (Initials)

ACKNOWLEDGMENT OF RECEIPT

By initialing, I acknowledge that Legacy Community Health Services has provided me with its: Notice of Privacy Practices, which explains how my health information will be handled in various situations; Client Rights and Responsibilities, which I agree to abide by; Grievance Policy, for filing complaints; and E-Prescribing Information Sheet .

_____(Initials)

FINANCIAL RESPONSIBILITY

By initialing below, I understand that if I qualify for services through a grant funded program such as Ryan White or the Department of State Health Services Family Planning (Title X) these resources are payers of last resort. Meaning that, if I currently or in the future have Medicare, Medicaid and/or third party insurance, I may not be eligible for services under these grants. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If such changes have not been appropriately reported and if those changes in my status result in my ineligibility for services under a grant funded program at Legacy Community Health Services, I understand that I am fully responsible for the cost of services delivered by Legacy Community Health Services.

_____ (Initials)

MEDICAID / MEDICARE / THIRD PARTY INSURANCE

By initialing below, if I become eligible for Medicaid, Medicare and/or third party insurance while a client of Legacy Community Health Services, I authorize Legacy Community Health Services to furnish Medicaid and/or Medicare and/or a third party insurer all of the necessary medical information including my HIV status to process my claim.

_____ (Initials)

By initialing below, I hereby assign to Legacy Community Health Services all payments from Medicaid, Medicare and/or any other third party insurer for medical services provided. I understand that I am responsible for the cost of services delivered that are not covered by my insurance. I also understand that I may be responsible for my co-pay to be paid prior to me being seen by a health care practitioner.

_____ (Initials)

CONSENT FOR COMMUNICATION WITH DELEGATED INDIVIDUAL

By initialing, I authorize Legacy to communicate with the following individual about my health care which may include information about my medical diagnosis, eligibility status and appointments.

First Name	Last Name	Relationship

_____ (Initials)

TERMS OF CONSENT

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Legacy Community Health Services and the Harris County Public Health & Environmental Services, and Ryan White Grant Administration, as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Client Name Printed	Initials

Signature of Client or Parent / Guardian or Power of Attorney	Date

Witness Signature	Date

Legacy
Community Health Services

ADULT MEDICAL HISTORY FORM

FOR PATIENT COMPLETION

Name: _____ **Today's Date:** _____ **Date of Birth:** _____ **Age:** _____

Please line through any questions that do not apply to you.

Current Medications (Include prescription and non-prescription drugs, birth control pills, herbs, supplements)

_____

_____

Allergies and Reactions (Medication and foods)

_____

_____

Are you currently under the care of a doctor? (List name and type of doctor)

_____ _____

Preventive Care (Write the date of your most recent)

_____Tetanus booster vaccine	_____Flu vaccine	_____Eye exam
_____Hepatitis A vaccine	_____TB skin test	_____Dental exam
_____Hepatitis B vaccine	_____HIV test	
_____Pneumonia vaccine	_____Syphilis-RPR test	

Family History (Include Mother [M], Father [F], Brother [B], Sister [S], Grandmother [GM], Grandfather [GF])

_____Cancer	_____Heart attack before age 50	_____Osteoporosis
_____Diabetes (insulin/diet control)	_____High blood pressure	_____Mental illness
_____Genetic problem/birth defect	_____High cholesterol	_____Other: _____

Personal Medical History (Check all that apply)

__ Chest pain, difficulty breathing	__ Cancer
__ Frequent or severe headaches	__ Birth defects
__ Numbness of arms or legs	__ Abdominal/pelvic pain or infection
__ Redness, pain in legs	__ Unusual vaginal bleeding or discharge
__ Stomach/bowel problems	__ Uterine fibroid or tumor
__ Kidney or bladder disease	__ Breast discharge/lump
__ Sickle cell trait disease	__ Discharge from penis
__ Blood transfusions	__ Hepatitis A, B, C
__ Anemia	__ Liver problems
__ High cholesterol	__ HIV
__ High blood pressure	__ Herpes, warts syphilis, chlamydia, and/or gonorrhea
__ Stroke	Do you think you are currently pregnant? __Yes __No
__ Heart murmur/problem	# of pregnancies: _____ # of live births: _____
__ Blurred or double vision	Date of last menstrual period: _____ ☐N/A - Menopausal

Name: _____

__ Swollen legs/ankles	Surgical history: (List)
__ Increase in thirst or urination	_____
__ Sores that do not heal	_____
__ Skin allergies/irritation	Emotional problems/depression: (List)
__ Seizure disorder	_____

Patient Mental Health Assessment

In the last 14 days have you experienced any of the following

Depressed/anxious mood, sadness/crying most of the day, nearly every day?	__ Yes __ No
Less interest or pleasure in all, or almost all, activities most of the day, nearly every day?	__ Yes __ No
A change in sleep patterns?	__ Yes __ No
Thoughts/attempts of hurting or killing myself or others?	__ Yes __ No
Have you heard or seen things that other people don't hear or see?	__ Yes __ No

Drug and Alcohol Use and History

Do you currently use tobacco? __ Yes __ No
How many per day?_____ For how long? _____

Have you previously used tobacco? __ Yes __ No
How many per day? _____ For how long? _____ When did you quit? _____

Do you currently drink alcohol? __ Yes __ No
How many per week? _____

Do you currently use drugs? __ Yes __ No
Types and how often: _____

Have you used drugs in the past? __ Yes __ No
Types, dates and how often: _____

I have answered all of the questions about my medical history and my present physical condition fully and truthfully. I have told the doctors or other designated health center personnel about any conditions I may have, which may affect my overall health care. It is my responsibility to inform my provider should this information change in the future. By signing below, I confirm that I have reviewed and answered the entire four page document. Any spaces left blank are not applicable to me.

_____ _____
Patient Signature Date

_____ _____
Reviewing Provider's Signature*** Date

By signing above, I confirm that I have reviewed the entire two page document and obtained clarification from the patient as necessary. Any blank spaces in this history form should be lined through by the patient and initialed by the reviewing provider to identify that if is not applicable to the patient.

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CONSENT & ACKNOWLEDGEMENT FOR OBTAINING E-PRESCRIBING HISTORY

Patient Name: _____ **Date of Birth:** _____

ACKNOWLEDGMENT OF RECEIPT OF E-PRESCRIBING INFORMATION SHEET

By initialing, I acknowledge that Legacy Community Health Services has provided me with its E-Prescribing Information Sheet, which explains the purpose and details on how my prescriptions and prescription refill history will be handled electronically. _____(Initials)

TERMS OF CONSENT

I understand that providing Legacy Community Health Services with a history of my current and past prescriptions will assist the agency in confirming the safety of my prescriptions and decreasing dangerous interactions with any other medications I may be taking.

☐ I hereby grant Legacy Community Health Services permission to obtain this medication history electronically from other healthcare organizations, including, but not limited to pharmacies.

☐ I **decline** the option of providing Legacy Community Health Services with a history of my current and past prescriptions.

By signing below, I agree that I am completing this consent of my own free will to consent as initialed above. I fully release Legacy Community Health Services, their employees, Board Members, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, claims, litigation, suits, proceedings, of any kind or nature whatsoever resulting from out of my receipt of this service.

I understand that this consent shall remain active until I withdraw my consent in writing at any time.

_____ _____
Client Name Printed Initials

_____ _____
Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____
Witness Signature Date

Legacy
Community Health Services

CONSENT FOR REVIEW OF RECORDS FOR RESEARCH

Legacy Community Health Services participates in research studies, which involve proven or experimental treatments. The staff of Legacy would like to review your records to determine if you are eligible to participate in current or future studies.

By signing this form, you are only indicating that you are willing to share the information located in your patient records with the Legacy research staff. The sole purpose of this information is to determine if you qualify for a research study. **You are not agreeing to be in a research study by signing this form**.

This consent may be revoked at any time, except to the extent that action may already have been taken in reliance on it.

Client Name Printed	Initials
Signature of Client or Parent / Guardian or Power of Attorney	Date
Witness Signature	Date