New Client Intake Form

Client Information

Last Name*: ___________________________ First Name: ________________________ Date of Birth: _______________

Social Security #: ________________________ ← This information will be encrypted for your protection.

Legal Sex*: __________ Marital Status: _________________ Email: ____

Address: ____ City: _________________ Zip: ________________

Cell Phone: _____________________ Work Phone: __________________ Preference: ☐ Cell ☐ Work

Emergency Contact Name: ____ Relationship: _______________________

Emergency Contact Phone: __________________________

Occupation: ____ Employer: ____

Primary Care Provider (PCP): ______________________________________ Phone: ____________________________

Referring Provider: ____ Phone: ____________________________

Preferred Pharmacy Address: ______________________________________ Phone: ____________________________

Primary Insurance Carrier**: ______________________________________ ID #: _______________ Group #: _________

Secondary Insurance Carrier**: ____________________________________ ID #: _______________ Group #: _________

*** Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**

**** Please refer to our website: https://wellnesshome.org/payment-methods, for a list of insurances accepted by your provider.**

Client Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Wellness Home on Halsted Healthcare providers for services rendered. I authorize representatives of Wellness Home on Halsted Healthcare providers to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Wellness Home on Halsted providers Notice of Privacy Practices (NOPP).

☐ Received
☐ N/A (only if you received the notice from Wellness Home on Halsted providers previously)

Information Disclosure and Consent

Wellness Home on Halsted Providers will provide you with the health plans that your provider(s) accept(s)**. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent from agreeing that you accept treatment from that provider.

Method of Contact?

The Wellness Home on Halsted Healthcare would like to know your communication preferences?

☐ Email ☐ Phone ☐ Text ☐ Mail ☐ I am ok with all these.

I read and agree to all the above (Financial Agreement, Notice of Privacy, Insurance Information).

Client or Legal Guardian Name (Print): ____

Client or Legal Guardian Signature: ____ Date: ___________

*** Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**

**** Please refer to our website:** https://wellnesshome.org/payment-methods**, for a list of insurances accepted by your provider.**

Voluntary Self Identification

Collection of the following information is encouraged by federal health agencies. It is used to monitor and improve the quality of care provided to all patients.

Ethnicity: ☐ Decline Response ☐ Hispanic / Latino ☐ Hon-Hispanic

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Race: ☐ Decline Response ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hawaiian Native or Pacific Islander

☐ White ☐ Other: ______________________

Gender and LGBTQ Identity

Gender: ☐ Decline Response ☐ Male ☒ Female ☐ Gender Nonconforming

☐ Transgender Male / Female to Male ☐ Transgender Female / Male to Female

☐ Additional / Other: ___________________________

Gender Assigned at Birth: ☐ Decline Response ☐ Male ☐ Female ☐ Unknown

Pronouns: ☐ He / Him ☐ She / Her They / Them

☐ Other: ________________________

Sexual Orientation: ☐ Decline Response ☐ Lesbian, Gay or Homosexual

☐ Straight or Heterosexual ☐ Bisexual

☐ Other: ______________________

Veteran's Status: ☐ Decline Response ☐ Protected Veteran ☐ Not a Protected Veteran

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Preferred language: _________________________________ ☐ Decline Response

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APPOINTMENT CANCELLATION POLICY

The providers and staff of Wellness Home on Halsted pride themselves on giving each client the appropriate amount of time and individual attention necessary to address their healthcare needs. In order to provide these services for you and our other patients, it is imperative for all patients to arrive 10 minutes prior to their scheduled appointment time.

If it is necessary to cancel or reschedule an appointment, a 24 hours' notice is required; if you must cancel or reschedule the same day of an appointment, a call is expected by 10:00 AM. If we do not receive a call by 10:00 AM to cancel your appointment, there will be a $25.00 no-show fee assessed to your account. Payment of no-show fees are required to be paid at your next appointment.

Subsequent appointment cancellations, late cancellations, and no-show appointments may impact your ability to continue care with your provider at Wellness Home on Halsted.

This policy allows for the providers' time to be appropriately utilized for clients requiring their care and attention.

______________________________	______________________________	________________
Printed Name	**Signature**	**Date**
______________________________	______________________________	________________
Witness Printed Name	**Signature**	**Date**

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Last Name: ________________________ First Name: ______________________ DOB: _____________

Social Security #: ______________________ Client ID #: _____________________

I, the undersigned, hereby authorize Wellness Home and Halsted to obtain protected health information in my health records form the entity or entities listed below. I understand that my records are protected as confidential under applicable state and federal statutes, and they cannot be disclosed without my consent unless otherwise stated in certain provisions in aforementioned statues. I understand that this consent shall remain effective for a period of one (1) year from the date of signature unless otherwise noted below, or until revoked in writing. Wellness Home and Halsted acknowledges that any re-disclosure of this information, depending on the nature of the information, may not be permitted without a specific written authorization by the patient as to the content of information to be released under regulations certain regulatory federal and state statues.

I, the undersigned, authorize the entity or entities listed below to release to Wellness Home on Halsted the following specific forms of information contained in my records as follows: HIV / AIDS diagnosis and testing information, genetic testing information, psychiatric and mental health diagnosis and treatment information, diagnosis and treatment of sexually transmitted diseases and infection, and substance abuse diagnosis and treatment. I also authorize that, in the event of death, a fully executed copy of my death certificate, including diagnosis and cause of death, is to be made available to Wellness Home on Halsted. Copies of this authorization are to be considered as valid as the original.

Provider / Facility Name: ____

Address / Phone / Fax: ____

The specific nature or extend of the information to be disclosed and the requested time frame of the requested records is **(check all that apply):**

☐ Admission & Hospitalization: ____________________ ☐ Medication history & list: ____________________

☐ Clinic / Progress / H&P notes:____________________ ☐ Operative & Surgical reports: _________________

☐ Emergency Room records: ______________________ ☐ Outpatient treatment records: ________________

☐ Immunization records: _________________________ ☐ Radiology Reports: __________________________

☐ Laboratory & Pathology reports: _________________

☐ HIV Genotype, Phenotype, & Resistance testing: ____

☐ CD4 count & Viral load: ____

☐ STD / STI test results (Chlamydia, Gonorrhea, Syphilis, Hepatitis C): ______________________________

☐ Other: ____

___________________________________ ___________________________________ __________________

Printed Name **Signature** **Date**

I *revoke* this authorization: ____ **Date:** _________________

3416 S. Halsted St., Chicago, IL 60608 | Tel: 773-823-9434 | Fax: 773-801-1854

GENERAL RELEASE OF RECORDS AUTHORIZATION TO INSURER

I hereby authorize Wellness Home on Halsted to release any and all of my records to my insurer or any other third-party payer legally responsible to payment of medical expenses for care provided by Wellness Home on Halsted.

I understand that this authorization allows Wellness Home on Halsted release to my insurer any information concerning me, including, but not limited to, confidential information, financial records, and the records of any treatment of examine rendered to me.

I understand that this release, and any future release which I may Sign, specifically allows for the release of my information to my insurer concerning my HIV test results and related data.

ASSIGNMENT OF MEDICAL BENEFITS, AGREEMENT TO REMAIN RESPONSIBLE

Name of Insurer: ____________________________________ Member ID #: ____________________________

Subscriber Name: ___________________________________ Subscriber Date of Birth: __________________

I hereby assign to Wellness Home on Halsted, in consideration for medical services to be provided, the right to receive payments form my insurer or any other third party who may, in the future, become legally responsible for payment of my medical expenses.

I have been informed of the cost of services provided my Wellness Home on Halsted agree to be responsible for such charges.

I understand that I shall remain legally responsible for payment of all charges that are for any reason not paid to Wellness Home on Halsted my insurer. I further understand that if I am unable to provide timely payment on any unpaid balance that I may be eligible for a payment plan and agree to discuss such options. Should Wellness Home on Halsted retain an attorney to collect any unpaid charges from me, I agree to pay reasonable attorney's fees and cost incurred by Wellness Home on Halsted.

I further authorize Wellness Home on Halsted and any attorney retained by Wellness Home on Halsted to use the file information to bring an action against my insurer. I further allow said attorney to discuss and release to my insurer any and all file information as deemed necessary and to file a complaint with the State Department of Insurance against my insurer.

Photocopies of this authorization shall serve as binding and effective as the original. This agreement may only be modified by written agreement of the parties.

_____________________________________ _____________________________________ ____________________

Printed Name **Signature** **Date**

_____________________________________ _____________________________________ ____________________

Witness Printed Name **Signature** **Date**

COMMUNICATION AUTHORIZATION

I, The undersigned, hereby authorize the following person(s) to receive information from my protected health record in relation to my medical condition (including the possibility of HIV related information or other protected diagnoses and treatments as protected by 410 ILCS 305/1 et. Seq., 740 ILCS 110/1 et. Seq., 20 ILCS 301/30-5, 42 USC 290dd-3, 290ee-3, and 42 CFT, Part II) from my physician or staff members of Wellness Home on Halsted. I also understand that I may revoke or change this authorization only upon written demand by completing the applicable fields below.

Authorized Person(s)

1. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________
2. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________
3. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________
4. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________
5. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________
6. ______________________________________ ☐ *Revoke authorization* *Revocation Date:* _________________

_______________________________________	_______________________________________	_____________________
Printed Name	**Signature**	**Date**

WELLNESS HOME OF NORTHSTART
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Wellness Home on Halsted's Notice Privacy Practices. I understand that if Wellness Home on Halsted uses my personal health information in a manner that is different than described by the notice, Wellness Home on Halsted must first get my permission in writing.

I am accepting this Notice on behalf of:

☐ Myself

☐ Another person as his or her personal representative (parent, guardian, family member etc.)

______________________________	______________________________	________________
Printed Name	**Signature**	**Date**

____

Relationship to Client

If you have received this correspondence by mail or electronic transmission, please return a signed copy of this form to:

Wellness Home on Halsted
Attention: Janine Espinosa
3416 S. Halsted St.
Chicago, IL 60608

WELLNESS HOME
GETFIT WEIGHT LOSS PROGRAM
a Baal Perazim Wellness Affiliate Company

Last Name*: __________________________ First Name: ______________________ Date of Birth: ______________

*** Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**
Reason for today's visit: ____

General Medical Questionnaire

1. Have you EVER had any of the following? **Check all that apply:**

- ☐ Asthma / Breathing Problems
- ☐ Arthritis
- ☐ Bleeding / Clothing Disorder
- ☐ Blood Pressure Disorder
- ☐ Blood Transfusion
- ☐ Bowel / Stomach Problems
- ☐ Cancer
- ☐ Cholesterol Disorder
- ☐ Diabetes
- ☐ Eye Disorder (e.g., Glaucoma, cataract, etc.)
- ☐ **If Relevant:** Gynecological Issues
- ☐ Heart Disease/Disorder
- ☐ Lung Disorder
- ☐ Liver Disease
- ☐ Neurological Disorder / Chronic Headaches
- ☐ Psychiatric Disorder / Illness
- ☐ Pulmonary Embolism / DVT
- ☐ Stroke
- ☐ Seizure or Epilepsy
- ☐ Thyroid Disorder
- ☐ Urinary / Kidney Disorder
- ☐ **If Relevant:** Prostate Issues

2. Please list any other medical illnesses or problems and provide details for any of the above conditions:

____
____
____
____

3. Please list ALL active treating physicians (e.g., pulmonologist, oncologist, internist, cardiologist, etc…):

Physician's Name: ______________________________ Specialty: ____________________________
Physician's Name: ______________________________ Specialty: ____________________________
Physician's Name: ______________________________ Specialty: ____________________________
Physician's Name: ______________________________ Specialty: ____________________________

4. Please list all past surgeries and hospitalizations and the approximate date:

Procedure / Hospitalization	Date	Complications

5. Please indicate any major conditions / illnesses that your immediate family members have had:

Relative	Condition and Description	Living?		If deccased, at what age?
Mother		☐ Y	☐ N	
Father		☐ Y	☐ N	
Sibling		☐ Y	☐ N	
Other		☐ Y	☐ N	

6. ☐ Current smoker ☐ Previously smoked ☐ Never smoked • Years smoked: _________ Packs / day: ________
7. Do you use other tobacco products? ☐ Y ☐ N
8. Do you consume alcohol? ☐ Y ☐ N • If yes, drinks / week: _________
9. **If Relevant:** Any past pregnancies? ☐ Y ☐ N • If yes how many? _________ How many deliveries? _________
10. **Do you have any allergies to medications or other substances (pets, food, etc.)**? ☐ Y ☐ N
    If yes, please list allergies and reactions (including rash, hives, throat swelling, and anaphylaxis):

Allergy	Rection	Allergy	Reaction

11. Please list All of your current medications, **including over the counter medications, supplements, and herbs:**

Medication Name	Dose	Medication Name	Dose

12. **Vaccines**
    Check all that apply, and please provide approximate dates if available, listing the most recent date of a series first:

Vaccination	Date(s)
☐ Influenza	
☐ Pneumonia (Prevnar 13 / Pneumovax / PNV 20)	
☐ Covid (Moderna / Johnson & Johnson / Pfizer / Bivalent)	
☐ Covid booster (Moderna / Johnson & Johnson / Pfizer / Bivalent)	
☐ Hepatitis B (Engerix-B / Recombivax HB / Heplisav-B)	
☐ Hepatitis A (Havrix / Vaqta)	
☐ Hepatitis A / B (Twinrix)	
☐ HPV (Gardasil® 9, 9vHPV / Gardsil® / 4vHPV)	
☐ Meningitis (Menactra / Menveo / MenQuadfi / Bexero / Trumbena)	
☐ Monkeypox	
☐ Tetanus (Td/Tdap)	
☐ Singles (Shingrix / Zostavax)	
☐ BCG (Tuberculosis)	

13. **Screening**
    Check all that apply, and please provide findings & approximate dates if available, listing the most recent date first:

Test	Findings/Results	Date(s)
☐ Anal Pap		
☐ Prostate Cancer (PSA)		
☐ Bone Density Test		
☐Mammogram		
☐ Cervical Pap		

☐ Colon Cancer (Colonoscopy / Cologuard / Stool cards)		
☐ EKG		
☐ Cardiac Echo		
☐ Cardiac Stress Test		
☐ Chest X-ray		
☐ CT Chest for Lung Cancer		
☐ US AAA Screening		
☐ Hepatitis		
☐ HIV		
☐ STD / STI		
☐ TB (PPD / Quantiferon Gold / Chest X-ray)		

14. Review of Systems

Please check ALL that you have experienced **within the past 6-12 months:**

Constitutional

☐ Fever
☐
☐ Fatigue
☐ Feeling Poorly
☐ Sweets
☐ Weight Gain (______ lbs.)
☐ Weight Loss (_______ lbs.)
☐ Unexpected Weight Change
☐ Sleep Disturbances
☐ Other:

Head, Eyes, Ears, Nose, and Throat

☐ Vision Problem
☐ Decreased Hearing
☐ Double Vision
☐ Light Sensitivity
☐ Itchy Eyes
☐ Red eyes
☐ Eye Pain
☐ Runny Nose
☐ Neck Stiffness
☐ Nosebleed
☐ Congestion
☐ Snoring
☐ Dry Mouth
☐ Flu-Like Symptoms
☐ Sore Throat
☐ Hoarseness
☐ Ringing in Ears
☐ Vertigo
☐ Earache
☐ Other:

Cardiovascular

☐ Chest Pain
☐ Palpitations
☐ Leg Swelling
☐ Cold Extremities
☐ Cold Hands or Feet
☐ Leg Pain w/ Walking
☐ Irregular Heart Rhythm
☐ Other:

Respiratory

☐ Shortness of Breath
☐ Cough
☐ Rapid Breathing
☐ Wheezing
☐ Chest Congestion
☐ Coughing Up Blood
☐ Coughing Up Sputum
☐ Other:

Gastrointestinal

☐ Abdominal Pain
☐ Blood in Stool
☐ Vomiting
☐ Nausea
☐ Constipation
☐ Diarrhea
☐ Black/Tarry Stools
☐ Decreased Appetite
☐ Yellow Skin
☐ Trouble Swallowing
☐ Change in Bowels
☐ Vomiting Blood
☐ Bowel Incontinence
☐ Rectal Pain
☐ Heartburn
☐ Painful Swallowing
☐ Other:

WELLNESS HOME
GETFIT WEIGHT LOSS PROGRAM
a Baal Perazim Wellness Affiliate Company

Neurological

☐ Headache ☐ Unsteady ☐ Numbness ☐ Tremor
☐ Dizziness ☐ Disorientation ☐ Tingling ☐ Memory Lapses/Loss
☐ Decreased Strength ☐ Confusion ☐ Seizures ☐ Other:
☐ Poor Coordination ☐ Burning Sensation ☐ Fainting (Syncope)

Musculoskeletal

☐ Joint Pain ☐ Limb Pain ☐ Muscle Pain ☐ Other:
☐ Neck Pain ☐ Joint Swelling ☐ Muscle Weakness
☐ Back Pain ☐ Muscle Cramps ☐ Leg Swelling

Genitourinary

☐ Frequent Urination ☐ Pelvis Pain ☐ Painful Intercourse ☐ Heavy Period Bleeding
☐ Incontinence ☐ Nocturia ☐ Discharge-Vaginal ☐ Other:
☐ Urinary Urgency ☐ Itching-Genital ☐ Vaginal Bleeding
☐ Painful Urination ☐ Change in Libido ☐ Irreg. Monthly Cycles

Integumentary

☐ Rash ☐ Skin Wound ☐ Unusual Growth ☐ Skin Cancer
☐ Dry Skin ☐ Change in A Mole ☐ Itching ☐ Other:

Psychiatric:

☐ Depression ☐ Anxiety ☐ Other:

Hematologic/Lymphatic

☐ Easy Bruising ☐ Easy Bleeding ☐ Swollen Lymph Nodes ☐ Other:

Endocrine

☐ Excessive Thirst ☐ Heat Intolerance ☐ Changes-Skin
☐ Cold Intolerance ☐ Changes-Hair ☐ Other:

OFFICE USE ONLY

Provider Notes:

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____________________________ ____________________________ ______________

Provider Printed Name **Signature** **Date**