1823 McCall Drive, Anniston, AL 36207 Tel: (256) 419-2041

PATIENT REGISTRATION FORM

Today's Date _____/_____/_____ **Patient Number**_____
Mo Day Year

Legal First Name _____ **MI**._____ **Legal Last Name**_____

Address _____ Apt#_____ Zip Code_____ City_____ State_____

Home Phone ( ) _____ - _____ Email Address_____ Secondary Phone ( )_____-_____

Contact Name _____ Emergency Phone (____)_____-_____

If we need to contact you, can we identify ourselves as the Salam Free Clinic? ☐ Yes ☐ No

Date of Birth _____/_____/_____ **Social Security #** _____-_____-_____ **Gender at birth ☐ Male ☐ Female**

Primary Language _____ **Do you need an interpreter? ☐ Yes ☐ No**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Unknown

Occupation: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Student ☐ Retired ☐ Military ☐ Others

If employed, please write name, address and telephone: _____

Are you a U.S. veteran? ☐ Yes ☐ No **Are you disabled? ☐ Yes ☐ No**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to State

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ More than one Race ☐ Unknown, Not Reported

Are you Hispanic / Latino? ☐ Yes ☐ No

Do you attend school, college or university? ☐ Yes ☐ No **If yes, write the name below**

_____

Are you homeless? ☐ Yes ☐ No **If yes, where did you stay / sleep last night**?_____

(Homeless is defined as any of the living situations described below):

☐ Shelter ☐ Street or Woods ☐ Friend's or Relative's Home ☐ Transitional Housing ☐ Treatment Facility

☐ Car, Boat or Other Vehicle ☐ Hotel or Motel (not provided by an agency) ☐ Hospital ☐ Jail or Prison

☐ Foster Care ☐ Permanent Housing for people who have been homeless ☐ Unknown

Salam Free Clinic, is a free clinic for the uninsured patients. I certify that I do not have any medical, dental or vision insurance.

Name _____ **Signature** _____ **Date** _____

SALAM FREE CLINIC

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Fax: 256-419-2051

Patient Name: _____ Date: _____

D.O.B: _____ Age: _____

Gender: Male/Female PPD: Date Placed: _____ Date Read: _____

Complaint: _____

_____

PMH: _____

_____

PSH: _____

_____

Meds/Vaccines: _____

Social History: _____

Family History: _____

ALLERGIES: _____ ROS: _____

HEET: _____ CV: _____

PULM: _____ GI: _____

GU: _____ OB/GYN: _____

MS: _____ NEURO: _____

DERM: _____ ENDO: _____

PSYCH: _____ HEM/ONC: _____

ABD: _____

LUNGS: _____ CVS: _____

NECK: _____

EXT: _____

PHYSICAL EXAM: _____ WT _____ BMI _____ VS: TEMP _____ RR _____ PULSE _____ BP _____

IMPRESSION: _____

PLAN: _____

_____

PROVIDER
NAME/SIGNATURE: _____ DATE: _____

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ENCOUNTER FORM

Patient Name: _____ D.O.B: _____

Phone Number: _____ Address: _____

Problem List:

Problem List: _____

Date: _____ Diagnosis: _____ Medication: _____

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Follow Up Date: _____

Patient Name: _____ D.O.B: _____

BP _____ Height _____ WT _____ BS _____ Temp _____ HR _____ RR _____

Reason for Follow up: _____

Physician's Notes: _____

Medication Prescribed:

Labs/X-Rays Ordered:

Recheck In: _____

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MEDICAL SCREENING FORM

Name: _____ **Date**:_____

CURRENT CONDITION:

Where are you currently having symptoms? _____

_____

When did these symptoms start? _____

How did this injury occur? (gradually, suddenly, injury): _____

My symptoms are currently: Getting Better / About the Same / Getting Worse

Please list any previous treatment for the condition we are seeing you for today? _____

_____

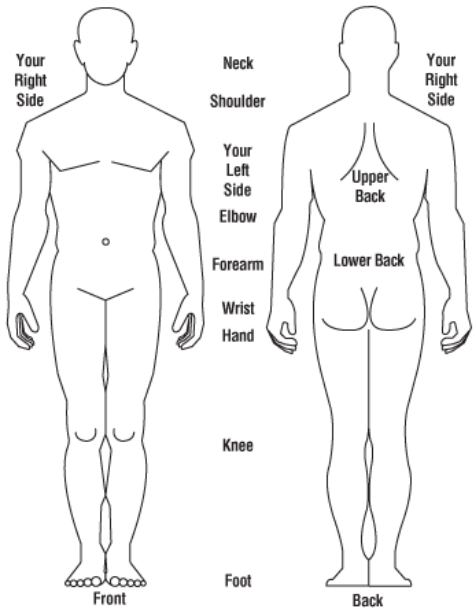
Have you ever had this problem before? ☐ Yes ☐ No

If so, how was the problem treated? _____

_____

Have you had any imaging studies done for this problem (x-rays, MRI, etc.)? ☐ Yes ☐ No

Please use the following symbols: ^^^ Numbness *** Pins & Needles //// Pain



Rate your pain (1=mild, 10=severe): At is worst: 1 2 3 4 5 6 7 8 9 10 **At its best: 1 2 3 4 5 6 7 8 9 10**

Right Now: 1 2 3 4 5 6 7 8 9 10

Currently, I am experiencing the following (check all that apply):

- ☐ Unexpected Weight Loss
- ☐ Increased Pain at Night
- ☐ Fever / Chills / Sweats
- ☐ Changes in Appetite
- ☐ Difficulty Swallowing
- ☐ Headaches
- ☐ Nausea / Vomiting
- ☐ Numbness or Tingling
- ☐ Dizziness
- ☐ Changes in Bowel or Bladder Function
- ☐ Depression
- ☐ Shortness of Breath
- ☐ Poor Balance / Falls

PAST MEDICAL HISTORY:

Please check any condition that you currently have or have had in the past:

□ High Blood Pressure	□ Stroke	□ Arthritis
□ Lung Disease / Problems	□ Cancer	□ Kidney Disease
□ Heart Disease / Problems	□ Diabetes	□ Liver Disease
□ Asthma / Allergies	□ Pacemaker	□ Angina
□ Circulation / Bleeding Problems	□ Osteoporosis	□ Fibromyalgia

Are you allergic to latex? □ Yes □ No
Do you smoke? □ Yes □ No
Are you pregnant? □ Yes □ No

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

Are you currently taking any medications? □ Yes □ No
If yes, please list ALL medications you are currently taking: _____
_____
_____
_____

Please list past surgeries and dates:
_____
_____
_____
_____

Please list any medical conditions you have that have not been documented above:
_____
_____
_____
_____

What are your physical therapy and / or fitness goals?
_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

OFFICE USE:

Blood Pressure: _____ **Heart Rate:** _____ **Date:** _____

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This is a Free Medical Clinic

Please Read - Your Legal Rights Are Affected

Under Alabama law, physicians and other health care professionals who provide care and treatment to patients at a Free Medical Clinic are not liable for civil damages as a result of their acts or omissions in providing such care and treatment. In other words, Alabama law protects physicians and other healthcare professionals who provide care and treatment to patients at a Free Medical Clinic from being sued for medical negligence or medical malpractice.

As a patient at the Salam Free Medical Clinic, your legal rights may be affected by this law.

If you have questions, please ask to speak with the Medical Director.

Patient Name: _____

Signature: _____

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NURSE NOTES

Patient Name: _____

Phone Number: _____

Date: _____ Time: _____

Date: _____ Time: _____

Date: _____ Time: _____