SALAM FREE CLINIC

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

PATIENT REGISTRATION FORM

Today's Date _______/_______/________
Mo Day Year

Patient Number______________________

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** ______________

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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? ______________________________

____

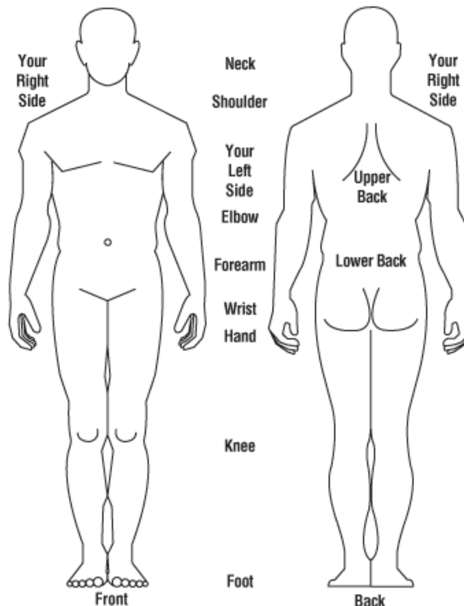
Have you ever had this problem before? □ **Yes** □ **No**

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
<u>Please Read - Your Legal Rights Are Affected</u>

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: ____________________________________