NEW CLIENT/PATIENT INTAKE FORM

Rachel Lee Patient Advocacy Consulting, LLC.

First Name …… **Last Name** ……

Preferred form of address (ie, nickname)……..

Date of Birth ……/……/……

Postal address ……..

City …… **State**…… **Postcode** ……

Daytime phone …… **Mobile** …… **Work** ……

Email address ……

May we leave a voicemail at this number containing medical information?.....

Emergency Contacts: Please provide two if possible

Emergency contact person …… **Relationship to patient** ……

Mobile number……..**Daytime phone** ……

May we discuss your medical information with this person?.....

May we leave medical details concerning your care on this persons voicemail if necessary?.....

Emergency contact person …… **Relationship to patient** ……

Mobile number……..**Daytime phone** ……

May we discuss your medical information with this person?.....

May we leave medical details concerning your care on this persons voicemail if necessary?.....

☐ Same As Above

Next of kin …… **Relationship to patient** ……

Mobile number……..**Daytime phone** ……

Optional: Demographic Information: *This information is used to provide you with personal support that is meaningful to you as a unique individual. Please use an extra piece of paper to provide any additional information you feel is important in this regard.*

Ethnicity: ……

Religious/Faith Preference if any……

In a few words, please describe the roll and significance of any religious/faith preferences and/or lifestyle preferences that you would like your advocate to be aware of? *Use extra paper if necessary.*

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Insurance: *Patient advocacy is not covered by an insurance network. This information is used for services we might perform on your behalf such as appeals, provider research and care planning.*

Insurance Network …… **Insurance Plan** ……

Contact number (next to name) …… **Policy Number** ……

Group Number ……

How did you hear about us?

☐ Google ☐ Facebook ☐ Family/friend recommendation ☐ Other ……..

MEDICAL INFORMATION

PATIENT NAME: …… **DOB** ……/……/……

Please <u>list</u> your current diagnoses *This will help your advocate be more efficient during the initial consult. You will be given time to explain them in detail at that time.* ***Use extra paper if needed.***

Please list any conditions that are undiagnosed but are suspected by and being investigated by a physician, as well as any "working" diagnoses.

Please BRIEFLY list any conditions or concerns <u>you</u> suspect butt that are NOT currently being investigated by a medical professional. *You will have time to give details during your initial consult. Provide only enough information for the advocate to know how to ask you about these concerns. Thank you.*

Please list any surgeries you have undergone:

Name:	**Date:**

Please list all current medications, including vitamins and mineral supplements. Use extra paper if necessary.

NAME	**DOSE**

NAME	**DOSE**

Are you undergoing any additional medical treatments? (ie, infusions). Please Explain.

_____

_____

_____

LIFESTYLE HEALTH HISTORY (specify approximate month/year)

Smoking history:-

- ☐ Never smoked
- smoker, quit date ……/……..
- ☐ Current smoker ……../day
- ☐ Number of years smoking ……..

Alcohol:-

Do you drink alcohol? ☐ yes ☐ no ☐ Former

Drinks per day …….

Drinks per week ……..

Are you currently following and particular diet or nutritional therapy? _____ If yes, please explain and indicate how consistent you on a daily basis. _____

_____

_____

Current Primary Care Provider Name_____

Contact Information_____

Are there any psychiatric or psychological diagnoses that would be pertinent to the client-advocacy relationship or any ongoing medical treatment? *Please see our statements about mental health in chronic illness in Client Rights and Responsibilities for more information about our deep respect for, and understanding of these types of diagnoses. RLPAC advocates have personal experience with how diagnoses of this kind can be misused. Any information provided is solely for the benefit of the client-advocate relationship and will not be used against the express wishes of the client.*

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Current and Past Physicians Sheet – Please provide, to the best of your ability, all medical health professionals you have seen or are currently seeing. *If you are having difficulty with this portion, your advocate can help you create this list as a part of your initial consult. Any information you can provide will help to streamline that process. Thank you.*

Name of the Provider	Name of the Network or Practice	Approximate dates you saw this provider
