



INTAKE FORM

For Office Use Only:
-Place processing label here -

Date: _____ Location: 7th Street McDowell Hope Mobile

Identifying Data (please print)
 Name: Last: _____ First: _____
 Date of Birth: MM / DD / YEAR _____ / _____ / _____ Age: _____
 Address: _____ Zip: _____
 Phone: () _____ - _____ Consent to Call or Text
 Email: _____ @ _____

Reason for Visit to PWC: Pregnancy test Consult Ultrasound IUD Removal Implant Removal Family Planning
 Infection Check UTI STI/STD test Well-woman Exam/PAP Breast exam Labs only
 Pregnancy Options Consult Abortion Pill Reversal Other: _____
1st visit to PWC?
 No Yes
Concerns Today: _____
Pharmacy (Name & Address): _____
How did you hear about us? Radio Google/online Clinic/Agency Friend/Family Signage Other: _____

Demographic Data:
Marital Status: Married Single Divorced Separated Cohabitation
Family Size: _____ (Total # in family) **Name of Spouse or Partner:** _____
Monthly Income: \$0-\$5,000 \$5,001-\$10K \$10,001-\$15K \$15,001-\$20K
Race/Ethnicity: Black Caucasian Hispanic Native American Asian
Religion: _____
Have Health Ins? Yes No
Occupation: _____ Last year of school completed: _____

Patient History: **Allergies (i.e. drug/food/environment):** None Known Yes: (List) _____
Current Medications: None Yes: (List) _____

Family History: **Parents:** None Unknown Cancer Diabetes Heart Thyroid Other: _____
Grandparents: None Unknown Cancer Diabetes Heart Thyroid Other: _____

Social History: **Alcohol:** None Yes: Amount: _____ Daily Weekly Monthly
Tobacco/Vape/eCig: None Yes: Amount: _____ Daily Weekly Monthly
Drugs: None Yes: Amount: _____ Daily Weekly Monthly
Birth Control: None Pill Condom IUD Implant Depo shot NuvaRing Tubal Ligation Withdrawal NFP
 Current Use:
 Past 24 mos.:
Number of sexual partners in the last 12 months: None #: _____
History of Domestic Abuse: No Yes

Surgical History: (DO NOT include pregnancies here) None

Year	Illness or Operation	Description
1. _____	_____	<input type="checkbox"/> Complications _____
2. _____	_____	<input type="checkbox"/> Complications _____
3. _____	_____	<input type="checkbox"/> Complications _____

Gynecological History:
If pregnant, intention: carry to term abortion adoption undecided
First day of menstrual period: _____ / _____ / _____ (most recent) **Are periods regular:** No Yes
Last sexual intercourse: _____ / _____ / _____
Pap Smear: None _____ / _____ / _____ **Normal?** Yes No: Treatment: _____
Mammogram: None _____ / _____ / _____ **Normal?** Yes No: Treatment: _____
HPV vaccine/Gardasil: No Yes
Blood Type: Unknown Type: _____ Pos / Neg

Continued on BACK

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HCG:	PR	LK	Nit	BL	GL	N&V <input type="checkbox"/>	SAB <input type="checkbox"/>	P.R. <input type="checkbox"/>	Rx <input type="checkbox"/>	PnV <input type="checkbox"/>
BP:										
P:										
WT:										

Obstetric History/Past Pregnancies:	<input type="checkbox"/> None	Total # of all Pregnancies:							Complications	C-Section
<u>Mo./Yr.</u>										
1. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
2. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
3. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
4. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
5. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
6. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			
7. _____	<input type="checkbox"/> Full term	<input type="checkbox"/> Premature	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Abortion	<input type="checkbox"/> Ectopic	<input type="checkbox"/> Multiple	<input type="checkbox"/> Living			

8 or more, Use Additional Form

Are you currently breast feeding? No Yes

Have you ever used the morning-after pill? No Yes: **When?** (date): _____

Past Medical History:

Breast problems: <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes
Female problems: <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes: <input type="checkbox"/> No <input type="checkbox"/> Yes
Infertility: <input type="checkbox"/> No <input type="checkbox"/> Yes	Endometriosis: <input type="checkbox"/> No <input type="checkbox"/> Yes
Sexually Transmitted Infections: <input type="checkbox"/> No <input type="checkbox"/> Yes	Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes
Sexual Abuse: <input type="checkbox"/> No <input type="checkbox"/> Yes	Psychiatric Illness: <input type="checkbox"/> No <input type="checkbox"/> Yes
Depression/Postpartum depression: <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Problems: <input type="checkbox"/> No <input type="checkbox"/> Yes
Birth Defects or Inherited Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Other: _____	

Phoenix Women's Clinic is not an emergency clinic and does not have a 24-hour answering service.

PLEASE READ AND SIGN AUTHORIZATION FOR SERVICES

- I hereby request Phoenix Women's Clinic to perform a pregnancy test and counseling. I understand that the results of the urine pregnancy test are 98% accurate according to the manufacturer. The earlier the test is done the greater the chance of error. I also understand that a pregnancy test **does not** constitute a clinic diagnosis of pregnancy. I hereby give my full consent to receive services and waive and release Phoenix Women's Clinic and its employees and volunteers from any and all liability arising out of, or connected with, this pregnancy test and particularly with regard to any errors based on this test.
- I hereby request services at Phoenix Women's Clinic for medical treatment and counseling. I understand that Phoenix Women's Clinic medical services are provided by a nurse practitioner, nurse and/or volunteer physicians. I understand that the scope of Phoenix Women's Clinic services is limited, and that if follow-up care is needed, I will be referred to appropriate health care providers. I further understand it is my responsibility to obtain any follow-up care.
- A limited ultrasound exam may be recommended, which can be done at Phoenix Women's Clinics. The ultrasound will be done only to confirm an intrauterine pregnancy and to determine fetal age. The ultrasound accuracy may vary up to 2 weeks. This procedure does not identify an ectopic pregnancy (a pregnancy developing inside the fallopian tubes) nor abnormalities of the reproductive organs or of the fetus.
- The counseling provided is not intended as a substitute for professional counseling.
- I understand that communication by text, phone or letter may be deemed necessary at the sole discretion of Phoenix Women's Clinic, and I hereby give permission for that contact to occur.
- I hereby give my full consent to receive medical services and waive and release any and all claims of any kind that I, my baby, my legal representatives, heirs and/or family members could have against Phoenix Women's Clinics, medical personnel, directors, officials, employees and volunteers. I expressly agree that this waiver and release of indemnity contract is intended to be as broad and inclusive as permitted by the laws of Arizona and also that if a portion of the same is held invalid, it is agreed that the remainder of the agreement shall continue in full force and legal effect.
- **Privacy Notice:** I understand that the staff of Phoenix Women's Clinic will have access to my confidential clinic records to provide for my medical care and for statistical purposes. My records will not be released to any agency or individual without my expressed permission, except as mandated by law. A patient copy of the Privacy Notice is available upon request.

I have read, understand, and agree with the above:

Patient Signature: _____ Date: _____ Print Name: _____

Witness: _____ Date: _____
Phoenix Women's Clinic Staff