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.	______	______________	☐ Complications	______
2.	______	______________	☐ Complications	______
3.	______	______________	☐ Complications	______

Gynecological History:

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
If pregnant, intention: ☐ carry to term ☐ abortion ☐ adoption ☐ undecided

Continued on BACK

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HCG:	*PR*	*LK*	*Nit*	*BL*	*GL*	*N&V ☐*	*SAB ☐*	*P.R. ☐*	*Rx ☐*	*PnV ☐*
BP:										
P:										
WT:										

PHOENIX WOMEN'S CLINICS

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Obstetric History/Past Pregnancies: ☐ **None** **Total # of all Pregnancies:** ____________

	Mo./Yr.								Complications	C-Section
1.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
2.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
3.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
4.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
5.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
6.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ Living		
7.	________	☐ Full term	☐ Premature	☐ Miscarriage	☐ Abortion	☐ Ectopic	☐ Multiple	☐ 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:	☐ No ☐ Yes	Cancer:	☐ No ☐ Yes
Female problems:	☐ No ☐ Yes	Diabetes:	☐ No ☐ Yes
Infertility:	☐ No ☐ Yes	Endometriosis:	☐ No ☐ Yes
Sexually Transmitted Infections:	☐ No ☐ Yes	Hypertension:	☐ No ☐ Yes
Sexual Abuse:	☐ No ☐ Yes	Psychiatric Illness:	☐ No ☐ Yes
Depression/Postpartum depression:	☐ No ☐ Yes	Thyroid Problems:	☐ No ☐ Yes
Birth Defects or Inherited Disease:	☐ No ☐ 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