

**Center for Black Women's Wellness, Inc.
Client Information Form**

All information is kept strictly confidential

Date of Service:		New Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>	
First name:		MI:	Last Name:
Date of Birth:	Age:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Social Security #:
Address:			Apt/Unit #:
City:		State:	Zip: County:
Home Phone:	Work Phone	Cell Phone	Email:
Race/Ethnicity: <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting	Education : (Indicate highest level completed) <input type="checkbox"/> Elementary(grades 1-8) <input type="checkbox"/> High School (grade ____) <input type="checkbox"/> HS Diploma <input type="checkbox"/> Vocational Training <input type="checkbox"/> Some College <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Graduate Degree	Source of Income: (check all that apply) <input type="checkbox"/> Full-Time Employment <input type="checkbox"/> Child Support <input type="checkbox"/> Part Time Employment <input type="checkbox"/> VA <input type="checkbox"/> TANF <input type="checkbox"/> Private Disability <input type="checkbox"/> Self Employed <input type="checkbox"/> Other _____ <input type="checkbox"/> SSI/SS _____ Payment Method: <input type="checkbox"/> Self Pay (credit card, money order) <input type="checkbox"/> Medicaid <input type="checkbox"/> PeachCare <input type="checkbox"/> Medicare Insurance Status <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance
Estimate of Total Household Income: <input type="checkbox"/> Less than \$10,999 <input type="checkbox"/> \$11,000 to \$19,000 <input type="checkbox"/> \$20,000 to \$29,999 <input type="checkbox"/> \$30,000 to \$39,999 <input type="checkbox"/> \$40,000 to 49,999 <input type="checkbox"/> 50,000 and up <input type="checkbox"/> Unknown			
Total Number of person(s) living in your household, including yourself: _____		Do you have children in your household under the age of 19? Yes <input type="checkbox"/> No <input type="checkbox"/>	
List all living persons in household (first and last name)	Male/Female	Age	Your relationship to this person (spouse/parent/grandparent/sibling/adoptive parent, aunt, etc.)
What service are you here for today? <input type="checkbox"/> Wellness Clinic <input type="checkbox"/> Safety Net Clinic <input type="checkbox"/> Askable Adult <input type="checkbox"/> Shots <input type="checkbox"/> WESSP Program <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> WIC Certification <input type="checkbox"/> Atlanta Healthy Start	Have you ever received services from CBWW? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, how did you find out about us? <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Clinic/Hospital <input type="checkbox"/> Other _____ <input type="checkbox"/> Internet		
Emergency Contact (someone not living with you)			
Name:		Relation:	
Address:			Apt/Unit#:
City:		State:	Zip: County:
Home Phone:		Work Phone:	

Thank you very much for completing this form for our funders

Signature of Person Completing Form: _____

To reduce wait time, please complete this form IN ITS ENTIRETY and submit to the front desk PRIOR TO starting all other forms. Thank you for your cooperation.



**CENTER FOR BLACK WOMEN'S WELLNESS, INC
WELLNESS CLINIC**

Initial Visit/Annual Exam Personal Health Questionnaire

Date: ____/____/____ Chart#: _____

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____ SS#: _____ - _____ - _____

Telephone: _____ (Home) _____ (Cell)

Emergency Contact (not living with you) _____ Relationship: _____

Address: _____ Telephone: _____

How did you hear about the Wellness Clinic? _____

Why are you visiting here today? _____

PERSONAL MEDICAL HISTORY

Check symptoms/conditions you currently have or have ever had in the past

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia (low blood) | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bleeding Disorders/Bruising | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems/ Ulcers |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Kidney Disease/Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Measles | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Epilepsy (fits, seizures) | <input type="checkbox"/> Multiple Sclerosis | |

Are you allergic to any foods or medicines? Yes No
If yes, what items? What happens to you when exposed to these items? _____

Have you ever been hospitalized? Yes No
If yes, when and what for? _____

Have you ever had surgery? Yes No
If yes, when and what kind of surgery? _____

SYMPTOMS/CONDITIONS

Check symptoms you currently have or have had in the past year

Gynecological

- Breast lump
- Hot flashes
- Nipple discharge
- Pain during sex
- Unpleasant vaginal odor
- Vaginal discharge
- Vaginal infections
- Vaginal itching or burning

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Frequent Headaches
- Frequent Tiredness
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

Urinary

- Blood in urine
- Frequent urination
- Painful urination
- Lack of bladder control

Cardiovascular

- Chest pain
- Shortness of breath
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sores that won't heal

List the medications that you are currently taking.

How many times a week do you exercise? _____ How many times a month do you exercise? _____

What types of exercise(s) do you do? _____

How would you describe your health on a scale of 1 to 10 (1 being poor and 10 being excellent)?

1	2	3	4	5	6	7	8	9	10
poor									excellent

FAMILY HISTORY

Certain health conditions sometimes run in families. Does anyone in your family have the following conditions?

Relationship? _____

Allergies () _____

Diabetes () _____

Heart Disease () _____

High Blood Pressure () _____

Kidney Disease () _____

Tuberculosis () _____

Cancer – What type? () _____

Are you doing anything to prevent the conditions that run in your family? If so, what? _____

OB/GYN HISTORY

General

Have you ever had a pap smear? Yes No

Date of last pap smear ____/____/____

Have you ever had an abnormal pap smear?

Yes No

If yes, when and where were you treated?

____/____/____

Do you do breast self-exams every month?

Yes No

If no, how often? _____

Do you have any discharge from your breasts?

Yes No

Do you have any breast masses or lumps?

Yes No

Date of last mammogram? ____/____/____

Normal Results

Abnormal Results

Are you sexually active? Yes No

Menstrual History

Age you were when periods started _____

Have you gone through menopause?

Yes No

Are your periods regular?

Yes No Varies

Date of last period ____/____/____

How many days are your there from the start of one period to the beginning of the next? _____

How many days do your periods last? _____

Flow: Light Medium Heavy

Describe the intensity of pain you experience with your periods: None Mild Moderate Severe

Crippling

Do you have bleeding or spotting between your periods?

Yes No

Do you have bleeding or spotting after sex?

Yes No

Birth Control

What method(s) for birth control do you currently use?

Have you ever taken birth control pills?

Yes No

If yes, when and for how long? _____

Other form(s) of birth control you have used:

Do you use condoms to protect yourself from STDs (Sexually Transmitted Diseases)? Yes No

If not, why not? _____

Have you ever had sex with someone who is an IV drug user, or who is bisexual or gay? Yes No

Have you ever had any of the following?

Gonorrhea

Chlamydia

Trichomonas

Herpes

Syphilis

Yeast

Bacterial Vaginosis

Human Papiloma Virus (HPV)

Are you experiencing any problems with sexual intercourse? Yes No

What and how often? _____

Pregnancy History

Have you ever been pregnant? Yes No
If yes, how many times have you been pregnant? _____
Have you ever had an abortion? Yes No
If yes, when? ____/____/____
How many children do you have? _____
Do you breastfeed? Yes No
Have any of your children died?
 Yes How many? _____ No

Were any of your children premature?
 Yes No
Have you ever had a miscarriage, stillborn child,
or abortion? Yes No
How old were you when you had your first child?

Do you have infertility problems? Yes No
If yes, please describe: _____

SOCIAL HISTORY

Do you smoke cigarettes or cigars? Yes No
If yes, how many per day? _____
If yes, for how many years? _____
Do you chew tobacco? Yes No
If yes, how often per day? _____
Do you drink beer, wine or liquor? Yes No
If yes, do you do so: Daily Weekly
 Monthly Every now and then
For how many years? _____

Have you ever been kicked, hit, or punched by your
spouse/boyfriend/partner?
 Yes No
If yes, when ____/____/____
If yes, are you still dating or living with this person?
Have you ever been forced to have sex? Yes No
If yes, at what age? _____

Do you use any of the following drugs?
To answer please use the codes below:
Past/Current (P/C)
Daily/Weekly/Monthly/Every Now & Then (D/W/M/E)
For how many years?

Marijuana/Blunts: Yes No
If yes: _____
P/C D/W/M/E # of years

Heroin: Yes No
If yes: _____
P/C D/W/M/E # of years

Crack: Yes No
If yes: _____
P/C D/W/M/E # of years

Cocaine: Yes No
If yes: _____
P/C D/W/M/E # of years

Crystal Meth: Yes No
If yes: _____
P/C D/W/M/E # of years

NUTRITION HISTORY

How often do you have a bowel movement?
 Two or more daily
 Once a day
 Two or three times per week
 Once a week
 Some weeks I don't have any
Have you had problems with constipation in the last year?
 Yes No

Have you had problems with diarrhea in the last year?
 Yes No
Do you take laxatives? Yes No
If yes, how often? _____
Have you ever had blood or pus in your stool?
 Yes No
If yes, when? _____

Do you use enemas? Yes No

If yes, how often? _____

Do you consider yourself:

- Underweight
- About the correct weight
- Overweight

Are you concerned about your and/or your eating habits?

- Yes No

Please take a moment to think about what you had to eat or drink in the last 24 hours. Then read the following list of food below and write down how many servings of each food you had yesterday as accurately as you can.

Beverages:

Water (8 oz. glass) _____ Coffee (cups) _____
Milk (8 oz. glass) _____ Tea (cups) _____
Juice (4 oz. glass) _____ Beer (12 oz. can) _____
Soft drink (12 oz. can) _____ Wine (6 oz. glass) _____
Liquor (1 oz. glass) _____

Breads, Cereals, & Starches

Bread (slice) _____ Pasta (cooked 4 oz.) _____
Cereal (bowl) _____ Potatoes (cooked 4 oz) _____
Grits (4 oz.) _____ Rice (cooked 3 oz) _____
Corn (cooked 3 oz) _____

Fruits and Vegetables

Cooked vegetables _____ Raw Vegetables _____

Canned fruit _____ Fresh Fruit _____

Meats (servings)

A serving size is the size of palm of your hand.

Beef _____ Lamb _____

Pork _____ Chicken _____

Seafood _____

Think of the largest serving of meat you had yesterday.

How was it cooked?

- Baked
- Boiled
- Fried
- Broiled
- Grilled

How many snacks did you eat yesterday (potato chips, nachos, candy bars, cookies, etc.)?

_____ snacks

YOUR HEALTH INTERESTS

Are you interested in attending workshops, seminars, or classes on any of the following health topics? Check all that apply.

- Adult CPR
- Aerobics/Exercise
- Alternative Therapies
- Breast Cancer
- Child Safety
- Colon Cancer
- Contraception
- Depression
- Diabetes
- Domestic Violence
- Grief Management
- Heart Disease/Hypertension
- HIV/AIDS
- Infant/Child CPR
- Nutrition/Diet
- Preconception/Prenatal Issues
- Prostate Cancer
- Sexually Transmitted Diseases (STDs)
- Smoking Cessation
- Stress Reduction
- Sudden Infant Death Syndrome (SIDS)
- Yoga

Would you like to be notified about workshops, seminars, or classes on the above selected topics? Yes No

Please list any other health topics that you are interested in.