UNITED HOSPITAL CENTER
Family Medicine
Patient Self-Reporting Intake Assessment

Adult Patient's Name: _____ Today's Date: _____

Please answer the following questions as appropriate:

ADVANCE DIRECTIVE INFORMATION	**Yes**	**No**	**N/A**	**Comments**
Do you have an Advance Directive (Living Will or Medical Power of Attorney)? If yes, please bring a copy for your record on your next visit.	☐	☐	☐	_____
If you do not have an advance directive, would you like to be provided with information on completing one?	☐	☐	☐	_____
NUTRITIONAL INFORMATION				
Are you on any type of special diet?	☐	☐	☐	_____
Would you describe your appetite as:	**Good [ ]**	**Poor [ ]**		
Have you noticed any recent (within the past month) significant weight gain or loss (10 lbs.)?	☐	☐	☐	_____
FUNCTIONAL INFORMATION				
Are you having difficulty performing the activities that you normally perform for yourself?	☐	☐	☐	_____
Are you having any difficult walking?	☐	☐	☐	_____
PATIENT SAFETY				
Do you feel the child has a safe home environment?	☐	☐	**Unsure**	_____
COMMUNICATION - Any Poblems?	☐	☐		

If you marked yes, please mark any problems you feel may cause you some difficulty in understanding your plan of care: Vision ( ) Hearing ( ) Reading ( ) Language ( )Other ( ) please list:

PAIN ASSESSMENT		
Is today's visit pain related?	☐	☐
If so, please answer the following questions:		
Are you currently having pain?	☐	☐
Have you had pain in the last few months?	☐	☐

If yes, answer the questions below and circle your pain rating on the scale or face:

Describe the exact location of your pain:_____

Frequency/Duration of the pain: [ ]Constant [ ]Intermittent [ ]Other:_____

Character/Type of pain: [ ]Burning [ ]Dull [ ]Pressure [ ]Heavy [ ]Sharp [ ]Cramping [ ]

Other:_____

What causes or increases the pain?_____

What relieves the pain or makes it better?_____

Current method of pain control:_____

Reviewed by Physician and discussed with patient