Today's Date : ______________________

Patient Name : ______________________________

Date of Birth: __________ Social Security # ___________

What is the reason for your visit today? ______________________________

Is this condition related to an ***Accident ?*** ☐ No ☐ Yes Date of Accident : ______________

If yes, check which applies: ☐ ***Work Related*** ☐ ***Auto Accident*** ☐ ***Other:*** ______________

Accident Details : ______________________________

Please read all information carefully. All of your paperwork must be filled out completely and correctly.

Please tell us if you are having any problems *TODAY* with the following:

Constitution

- Y N Chills
- Y N Fatigue
- Y N Fever
- Y N Recent Weight Loss

Eyes

- Y N Itching
- Y N Matting / Discharge
- Y N Pain
- Y N Eyelid Redness
- Y N Vision Changes

ENT / Mouth

- Y N Ear Drainage
- Y N Ear Pain / Pressure
- Y N Hearing Loss
- Y N Hoarseness
- Y N Popping of Ears
- Y N Post-nasal Drip
- Y N Sinus Pressure/Drainage
- Y N Sore Throat
- Y N Stuffy Nose
- Y N Tinnitus (ear ringing)
- Y N Toothache

Cardio

- Y N Chest Pain/ Pressure
- Y N Palpitations
- Y N Shortness of Breath

Respiratory

- Y N Cough
- Y N Coughing Blood
- Y N Shortness of Breath
- Y N Wheezing

GI

- Y N Abdominal Pain
- Y N Bloating
- Y N Constipation
- Y N Diarrhea
- Y N Gas / Indigestion
- Y N Nausea / Vomiting
- Y N Rectal Bleeding
- Y N Rectal Pain

GU

- Y N Blood in Urine
- Y N History of STD
- Y N Painful Urination
- Y N Pregnancy
- Y N Urinary Frequency
- Y N Vaginal Discharge

Muscle / Skeletal

- Y N Back Pain
- Y N Joint Pain
- Y N Muscle Aches
- Y N Muscle Spasm
- Y N Neck Pain
- Y N Swelling in an Extremity

Skin / Breast

- Y N Bites / Sores
- Y N Breast Lump
- Y N Color Change
- Y N Itch
- Y N Lesion
- Y N Rash

Hema/ Lymph

- Y N Bleeding
- Y N Easy Bruising
- Y N Painful/ Swollen Lymph Node

Allergy / Immunization

- Y N Allergies
- Y N Hay Fever / Sneezing
- Y N Hives
- Y N Recurring Infections

Neurological

- Y N Dizziness
- Y N Headache
- Y N Loss of Consciousness
- Y N Muscle Weakness
- Y N Numbness / Tingling
- Y N Paralysis / Paresis
- Y N Poor Balance
- Y N Speech Difficulties

Psych

- Y N Anxiety
- Y N Depression
- Y N Insomnia (difficulty sleeping)

Patient Allergies: ______________________________

Current Medications : ______________________________

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Consent for services and / or disclosure of Protected Health Information: I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Velocity Care Urgent Care. I also understand that Velocity Care Urgent Treatment Center may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize the release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

______________________________ ______________

Signature of patient or parent/guardian if minor Date