The Healing Sanctuary
an affiliate of Mountain View Hospital

Patient Intake Form

Name: _____ **DOB**:_____ **Preferred Pharmacy**: _____

What are your top 3 priorities for today's visit?

1. _____
2. _____
3. _____

Do you have Advanced Directives? YES NO

Do you have any **NEW** allergies? IF SO, what type of reaction? _____

Do you have any **NEW** medications?_____

Did you receive the flu vaccine in the prior flu season? YES NO
Did you receive the flu vaccine this current flu season? YES NO

DEPRESSION SCREENING

How often have you been bothered by the symptoms below over the last two weeks?

Little interest or pleasure in doing things in the last 2 weeks? Please circle

Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks? Please circle

Not at all Several day More than half the days Nearly every day

Social History

(For pediatric patients, please mark yes or no if there has been exposure in the household to the below items)

Category	Yes	No	Usage
Tobacco			
Vaping			
Alcohol			
Substance			

Please answer if you are 50 years or older:

Have you ever received a Pneumonia vaccine? YES NO
If yes, was it less than 5 years ago? YES NO

Fall Risk Assessment *(Only answer if you are 65 years or older)*

Are you 65 years or older?	Yes	No
Have you had any falls within the past year?	Yes	No
Have you had a fall with injury?	Yes	No
Do you have a fear of falling?	Yes	No
Do you feel unsteady when standing or walking?	Yes	No

Patient Sticker
Last _____
First _____
DOB _____
FIN _____

NOT TO BE SCANNED IN THE MEDICAL RECORD