InterFaith Health Center
Comprehensive Affordable Care

Medical & Mental Health Services
315 Gill Ave.
Knoxville, TN 37917
865-546-7330
InterFaithHealthCenter.org

Dental Services
2607 Kingston Pike, Ste 185
Knoxville, TN 37919
865-243-3033

Date: _____

How many people are in your household? ____ Total household income (before taxes):_____

First name:_____ Middle:_____ Last:_____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home phone: _____ Cell phone: _____ Work: _____

Social security number: _____ Date of birth: _____ Sex: M / F / Non-Binary

Marital Status: Single Married Divorced Widowed Domestic Partnership

Race: Black White Hispanic Asian Other: _____

Country of birth: _____ First language: _____

EMPLOYMENT

Are you currently employed? Yes or No Industry/field of work: _____

If yes, place of employment:_____ Occupation:_____

If no, what is your source(s) of income: _____

In not working, reason: _____Date last worked: _____

If unemployed but with an employed spouse, where do they work? _____

Are you on unemployment? Yes or No Are you on disability? Yes or No

If you are on disability, when do you expect to receive Medicare? _____

Are you receiving workers comp? Yes or No If yes, list reason: _____

Are you on Medicare? Yes or No If yes, what part: _____

Do you have medical insurance? Yes or No If yes, please see the front desk

EMERGENCY CONTACTS

Name: _____ Phone # _____ Relationship: _____

Name: _____ Phone # _____ Relationship: _____

Who referred you to InterFaith Health Center? (for example a health department, hospital, ER, doctor or friend) _____

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HEALTH INFORMATION

What is the reason for your visit today?

_____

_____

Please circle if you have any of these symptoms:

Change in vision	Nosebleeds	Sores in mouth	Trouble swallowing	Food getting stuck	Heartburn/acid reflux/belching acid
Shortness of breath	Shortness of breath when lying down	Shortness of breath when going up stairs or walking	Cough	Chest pain	Coughing up phlegm every day
Palpitations/ fast heartbeat	Abdominal pain	Bloating	Constipation	Change in bowels	Lumps or bumps of concern
Change in mole	Itching all over	Night sweats	Fever	Weight loss ___lbs	Weight gain ___lbs
Change in vaginal discharge	Change in urine	Bleeding after menopause	Discharge from penis	Snoring	Irregular breathing during sleep
Suicidal ideation	Depression	Anxiety	Sleeplessness	Elevated mood	

Please list all current medical problems and the date they began:

_____

_____

_____

Please list previous surgeries and the date of those surgeries:

_____

_____

Please list all hospitalizations, reasons of hospitalizations and dates:

_____

_____

Medications	Dosage (if known)	Number of pills/shots per day
Do you take any vitamins? Y / N If yes, please list		
Do you take calcium? Y / N		

Medical History

When was your last:	Date or answer:
Mammogram	
Prostate exam	
Colonoscopy	
Tetanus shot	
TB skin test	
Pneumonia vaccine	
COVID-19 vaccine (and booster if received)	
Flu vaccine	
Pap smear	
Has your pap smear ever been abnormal?	Yes or No
Have you ever had any treatment for an abnormal pap smear?	Yes or No
When was your last menstrual cycle?	

Medical History Continued

Question:	Answer:
How many pregnancies have you had?	
How many vaginal births?	
How many C-Sections?	
Do you examine your breasts every month?	
What kind of birth control do you use?	

Family History

Do you have a family history of any of the following? Please circle

Aneurysm or Stroke	Heart attack, bypass, or stent	Sudden death before age 50
Blood clots of blood disease or free bleeding	Kidney disease or dialysis	Diabetes
Severe mental illness	Liver disease	Thyroid disease
Osteoporosis, broken hip or hunched back	Alcoholism or drug abuse	

Cancer of: Prostate Breasts Pancreas Melanoma Colon or polyps Ovary Uterus
Other: _____

If you circled any of the above conditions, please list which medical condition and family member effected:

_____

_____

_____

What is your activity level? Sedentary Moderately Active Active Very Active

Are you allergic to any medications? Y / N If yes, please list:_____

Can you read and write? Y / N

Do you have a translator? Y / N

Do you need a translator? Y / N If yes, what language? _____

Do you ever have a difficult time obtaining food? Y/N

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Social History

Do you drink alcohol? Y / N If no, please move to the next section.

Have you ever felt you ought to cut down on your drinking? Y / N

Have people annoyed you by criticizing your drinking? Y / N

Have you felt bad or guilty about your drinking? Y / N

Have you ever had a drink first thing in the morning to steady your nerves, to get rid of a hangover, or as an “eye opener”? Y / N

Do you consume drugs other than those required for medical reasons? Y / N

If no, please move to the next section

1. Have you ever felt you ought to cut down on your drug use? Y / N

2. Have people annoyed you by criticizing your drug use? Y / N

3. Have you felt bad or guilty about your drug use? Y / N

4. Have you ever used drugs first thing in the morning to steady your nerves, to get rid of a hangover, or as an “eye opener”? Y / N

Do you struggle with feelings of depression, isolation, or loneliness? Y / N

Do you struggle with feelings of anxiety, increased worry, or panic? Y / N

Do you have any significant life events that still worry you and haven’t talked about before? Y / N

Would you like to speak to the mental health counselor at InterFaith? Y / N

Do you smoke, vape, or use tobacco? Y / N (Please circle which one if yes)

If no, please move to the next section

What age did you start using? _____

How many packs a day? _____ (if applicable)

Have you ever had a sexually transmitted disease? Y / N

Do you have tattoos? Y / N

Have you ever had Hepatitis B or C? Y / N

Do you have HIV? Y / N

Have you ever injected drugs into your veins? Y / N

Have you ever had sex with an IV drug user? Y / N

Please read and sign the following agreements

I have received a copy of InterFaith Health Center's Statement of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Witness Date

InterFaith Health Center and its staff have permission to do the following: (please initial lines)

___ Contact ONLY me with any test results, information or questions at the following numbers:

_____ or _____

___ Leave test results on my answering machine/voicemail

___ Leave general information or questions on my answering machine/voicemail

AND/OR

___ Can speak to _____ (name) _____ (relation to patient) at phone number: _____

___ Leave test results

___ Leave general information or questions

_____ _____ _____ _____

Patient Signature Date Witness Date

Consent to Treat

I, _____(patient name) give permission for InterFaith Health Center to give me medical treatment.

I understand that:

I must pay the agreed upon cost for services I receive.

InterFaith Health Center reserves the right to discontinue medical services for any of the following: multiple no-shows, non-payment of services, unacceptable patient behavior.

I must provide financial information to requalify for services once a year.

Healthcare students may be present during my care.

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____

Print name

_____ _____

InterFaith Health Center Staff Date