Clarii Health
MEDICAL MANAGEMENT

Patient Registration

Full Name:		
Date of Birth:		***Last 4 of SSN:***
Address:		
City:	***State:***	***Zip code:***
Home phone:		***Cell Phone:***
Marital Status: Single Widowed Divorced Married		
Race:	***Ethnicity:***	***Preferred Language:***
Occupation:		
Preferred Pharmacy: *(Name **and** number OR address)*		

Primary Insurance Information	
Insurance Name:	
Name of policy holder:	**DOB of policy holder:**
Relationship to the patient:	
Policy ID #:	**Group #:**

Secondary Insurance Information *(if applicable)*	
Secondary Insurance Name:	
Name of policy holder:	**DOB of policy holder:**
Relationship to the patient:	
Policy ID #: Group #:	

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Name: _____ **Date of Birth:** _____

Cell phone: _____ **Email address:** _____

• If you are new today, *how* did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Please list any medical conditions that you have *and* when they started ♦
• •

♦ List medications you currently take ♦
• • •

♦ *Medication ALLERGIES* ♦	
Medication Name:	***Reaction:***

♦ Social History ♦	
How many **days** per week do you drink alcohol**?**	How much caffeine do you drink daily**?**

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If you're a smoker, # of yrs smoked**? Daily amount?**	If former, when did you quit? (& how much daily?)
How often do you exercise *and* how long**?** (example: 30 minutes 5 days a week)	
When was your last Annual Physical? *(many insurances will only cover 1 per 365 days)*	

Surgical History *List any previous surgeries **and** their approximate **date***	

♦ Family Health History ♦ ***Please list below the health history of your blood (genetic) first-degree relatives***	
Relative *(sister, mother, **p**aternal/**m**aternal GF/GM?)*	***Conditions***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests (If you remember)

	Month/ Yrs		***Month /Yr***		***Month/Yr***
Shingles Vaccine		Flu Shot		Bone Density (DEXA)	
Pneumonia Vaccine		Tetanus Vaccine (TD or TDAP)		COVID Vaccine/ Type	
Pap Smear		Mammogram		Colonoscopy	

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Over the last 2 weeks,

How often have you been bothered by any of the following problems?

Please circle your answer to each of the questions below.

1. Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
2. Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	Not at all	Several days	More than half the days	Nearly every day
4. Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly every day
5. Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly every day
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	Not at all	Several days	More than half the days	Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	Several days	More than half the days	Nearly every day
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Not at all	Several days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead, or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly every day
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3