TRI VALLEY
HEALTH SYSTEM

WALK-IN INTAKE FORM

Please present your insurance card at the time of check in. Settlement of patient financial responsibility is expected at time of service.

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

Pharmacy:_____ **Primary Care Provider:**_____

Are you experiencing any of the following?

SEVERE Chest Pain
SEVERE Trauma/Injury
Uncontrolled bleeding
Allergic Reaction
SEVERE Shortness of Breath
Stroke Signs and Symptoms
Motor Vehicle Accident
Any other life-threatening condition

Please stop and notify receptionist immediately

If no, continue this form.

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1. **Please state your reason for today's visit:**

_____

2. **Is this an on-the-job or other work related injury?** If no, Skip #2

Employer Name:	
Street Address:	City, State, Zip
Supervisor:	Date of Injury:

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3. **Review of Symptoms:**
   To help us better treat your illness; please select if you have any of these symptoms.

General: ☐Recent Fever ☐Recent Chills ☐Unexplained fatigue/weakness **Eyes:** ☐Blurred Vision ☐Eye Pain ☐Eye Drainage **Ears/Nose/Throat/Mouth:** ☐Difficulty Hearing ☐Continuous post nasal drip ☐Hoarseness of voice change ☐Sore Throat ☐Ear Pain **Cardiovascular:** ☐Chest pains/discomfort ☐Palpitations **Respiratory:** ☐Chronic Cough ☐Wheezing ☐Acute Cough ☐Shortness of Breath	**Gastrointestinal:** ☐Heartburn ☐Acid Reflux ☐Nausea/vomiting ☐Diarrhea ☐Abdominal Pain **Genitourinary:** ☐Painful urination ☐Nighttime urination ☐Frequent Urination ☐Discharge **Musculoskeletal:** ☐Muscle Pain ☐Joint Pain ☐Joint Stiffness ☐Recent Back Pain ☐Recent Fall **Skin :** ☐Rashes or itching ☐Fungal nail infection ☐Warts ☐Dry skin **Allergy/Immunologic:** ☐Seasonal Allergies ☐Altered Immune System	**Neurological:** ☐Headaches ☐Memory Loss ☐Fainting ☐Dizziness ☐Numbness **Blood/Lymphatic:** ☐Unexplained lumps/nodes ☐Excessive bleeding ☐Easy Bruising **Endocrinology:** ☐Excessive sweating ☐Thyroid trouble ☐Cold/heat intolerance ☐Increase thirst/appetite **Psychiatric:** ☐Anxiety/Stress ☐Sleep problems ☐ Depression in the last 2 Weeks ☐Loss of interest in normal activities

4. **If not listed above please describe:**

   _____

   _____

5. **Please have your medication and allergy list ready for when the nurse calls you back**