re:assuredadvocacy
HEALTHCARE NAVIGATION

# Client Information

Date _____

Patient/Client Name _____
FIRST M.I. LAST

What would you like to be called? _____

Address _____
STREET

_____
CITY STATE ZIP

Phone _____
HOME WORK CELL

Email _____

Date of Birth _____ Gender ☐ M ☐ F

Health Insurance _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No If not, who lives with you? _____

How did you hear about ReAssured Advocacy? (mark all that apply)

☐ Friend or relative _____ ☐ Internet
NAME

☐ Physician _____ ☐ Other _____
NAME

Describe how ReAssured Advocacy can help you:

☐ Coordinating and scheduling appointments/treatments/tests
☐ Attending appointments and communicating with family/caregivers
☐ Researching diagnoses, treatments, physicians, second opinions
☐ Researching housing options such as senior living communities
☐ Billing/claims/insurance issues
☐ Other

Please explain _____

_____

_____

_____

**Emergency Contact**

Name _____
FIRST LAST

Relationship to patient _____

Address _____
STREET

_____
CITY STATE ZIP

Phone _____
HOME WORK CELL

Email _____

**In addition to your emergency contact which family, friends, or caregivers would you like involved in your care or would like us to share information with?**

1 Name _____
FIRST LAST

Relationship to patient _____

Address _____
STREET

_____
CITY STATE ZIP

Phone _____
HOME WORK CELL

Email _____

2 Name _____
FIRST LAST

Relationship to patient _____

Address _____
STREET

_____
CITY STATE ZIP

Phone _____
HOME WORK CELL

Email _____

## Patient's Primary Care Physician

Name _____
FIRST LAST

Specialty _____

Office Address _____
STREET

_____
CITY STATE ZIP

Phone _____ Email _____
WORK CELL

## Other physicians you see

1 Name _____
FIRST LAST

Specialty _____

Office Address _____
STREET

_____
CITY STATE ZIP

Phone _____ Email _____
WORK CELL

2 Name _____
FIRST LAST

Specialty _____

Office Address _____
STREET

_____
CITY STATE ZIP

Phone _____ Email _____
WORK CELL

3 Name _____
FIRST LAST

Specialty _____

Office Address _____
STREET

_____
CITY STATE ZIP

Phone _____ Email _____
WORK CELL

**Health History**
Please check if you have, or have had any of the following:

**General**
- ☐ Allergies (drug, food, environmental, pet or seasonal)
- ☐ Anxiety
- ☐ Depression
- ☐ Hearing loss
- ☐ Vision loss
- ☐ Insomnia
- ☐ Sleep Apnea
  If yes, do you use a CPAP machine?
  ☐ yes ☐ no
- ☐ Other_____

_____

_____

**Cardiovascular:**
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Blood thinners (Coumadin/Warfarin)
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Hypertension (High Blood Pressure)
- ☐ High Cholesterol
- ☐ Other_____

_____

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**Endocrine**
- ☐ Diabetes
  - ☐ Insulin Dependant
  - ☐ Non-Insulin Dependant
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Gout
- ☐ Other_____

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_____

**Respiratory**
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Embolism
- ☐ Tuberculosis
- ☐ Other_____

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_____

**Gastrointestinal/Genitourinary**
- ☐ Hepatitis (type)_____
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Reflux/GERD
- ☐ IBD Irritable Bowel Disease
- ☐ Ulcers
- ☐ Liver Disease
- ☐ Other_____

_____

_____

**Cancer**
- ☐ Type _____
- ☐ Radiation
- ☐ Chemo

**Neurological**
- ☐ Stroke
- ☐ TIA
- ☐ Dementia
- ☐ Alzheimers
- ☐ Epilepsy
- ☐ MS
- ☐ Seizures
- ☐ Parkinson's
- ☐ Other_____

_____

_____

**Please list any other health issues including recent surgeries, tests or hospitalizations** _____

_____

_____

_____

_____

**Medications**

Please list all medication you are taking including over the counter medications.

| Name | Purpose | Dose/ Times of day | Prescribing Physician |
|---|---|---|---|
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**Retired?** ☐ Yes ☐ No

Occupation now or before retirement _____

**Do you drive?** ☐ Yes ☐ No **Do you use:** ☐ Wheelchair ☐ Walker ☐ Cane

**Interests/ Hobbies**

☐ Exercise ☐ Gardening
☐ Reading ☐ Cards
☐ Travel ☐ Other _____

**Notes**