

New Client Form

PART 1

NAME:			DATE OF CLINIC VISIT:		
DATE OF BIRTH:		AGE:	LAST FOUR OF SSN:		
PRIMARY PHYSICIAN:			HOME TELEPHONE:		
HOME ADDRESS:	Street:		WORK TELEPHONE:		
	City:	State:	Zip:	EMAIL ADDRESS:	

PART 2

How did you hear about us? (Please check the appropriate category):	<input type="checkbox"/>	Physician	<input type="checkbox"/>	CARE International	<input type="checkbox"/>	Home Depot	<input type="checkbox"/>	TVSA
	<input type="checkbox"/>	Travel Agent	<input type="checkbox"/>	AT&T	<input type="checkbox"/>	Employer	<input type="checkbox"/>	
	<input type="checkbox"/>	Friend/ Family	<input type="checkbox"/>	Mission Group	<input type="checkbox"/>	Internet/ Advertisement	<input type="checkbox"/>	

PART 3

ALLERGIES: MEDICAL HISTORY:	Have you ever had:		No	Yes	Is there a family history of mental health problems? Are you allergic to eggs or egg products?	No	Yes
	Seizures		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Irregular heartbeat		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Psoriasis		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Depression		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
MEDICATIONS:							

PART 4

COUNTRIES TO BE VISITED	ARRIVAL DATE	DEPARTURE DATE

Have you ever traveled before and if so, to where:

TYPE OF TRAVEL FOR THIS TRIP	<input type="checkbox"/>	Urban/ City	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Mission Work	<input type="checkbox"/>	Visiting Family
	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Business	<input type="checkbox"/>	Relocating	<input type="checkbox"/>	

PART 5

IMMUNIZATION HISTORY					
Immunization	Date	Immunization	Date	Immunization	Date
Tetanus/Diphtheria		Polio		Typhoid	
Hepatitis A #1		Hepatitis A #2		Yellow Fever	
Hepatitis B #1		Hepatitis B #2		Hepatitis B #3	
Japanese Encephalitis #1		Japanese Encephalitis #2		Japanese Encephalitis #3	
Meningococcal		Measles/Mumps/Rubella			

PART 6

All professional services rendered are charged to the client with the exception of corporate accounts with prior payment arrangements. Many insurance companies do not cover vaccinations. We therefore require payment at the time of service.

You will receive a copy of your bill that you can submit to your insurance company for proper reimbursement.

I have read and agree to the above conditions:

Client Signature

Date

Nurse/ Physician Signature

Date