Tennessee Valley Family Care

Stephanie D. Tucker MSN, FNP-C Elizabeth R. Phillips FNP-C and Kathy E. Cohen FNP-C

Patient Demographics

Thank you for selecting our healthcare team! Our goal is to provide you with the best possible care. To help us meet your healthcare needs, please fill out the form completely in ink. We will be glad to assist you in any way possible.

ADULT Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____

SS# _____ **Birthdate:** _____ **Marital Status** ☐ Single ☐ Married ☐ Separated ☐ Divorced

Race:
☐ White ☐ Black ☐ Asian ☐ Hispanic
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Other_____ ☐ Decline

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐Decline

Sex:
☐ Male
☐ Female
☐ Transgender
☐ Decline

Mailing Address: _____ **Physical Address:** _____

City: _____ **State:** _____ **Zip:** _____

Email for Patient Portal registration : _____

Employer: _____ **Occupation:** _____

Home Phone # _____ **Cell Phone#** _____ **Work Phone #:** _____

Preferred Method Of contact for Reminder Calls and Other Electronically generated Messages: ☐ **Voice** ☐ **Text** ☐ **Both**

If Voice, Please select Preferred Number: ☐ Home ☐ Cell ☐ Work

I_____ **agree to allow Tennessee Valley Family Care's staff to:**

☐ Leave a message Exclusively with me Only.

☐ With _____ (specify name and relationship).

Voice or Text messages Regarding (please mark all that applies):

☐ Appointment ☐ Referrals ☐ Pending test results ☐ Rx Information ☐ Billing Information ☐ Other :_____

Emergency Contact

Name: _____ **Relationship:** _____

Home: _____ **Work:** _____ **Cell:** _____

(Please circle all applies) Please provide a copy for office to keep on file if one is available.

Do You have: Power Of Attorney Living Will Advanced Directive None Would like an Advance Directive

Pharmacy:

Primary Pharmacy: _____ City: _____ Pharmacy Number: _____

Secondary Pharmacy: _____ City: _____ Pharmacy Number: _____

How did you hear about our practice? _____

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Primary Insurance Information

Primary Insurance Name: _____

Policy#: _____ _____Group#: _____

Name of Insured: _____ Relationship to Patient:_____

Insured's Birthday: _____ ___ SSN: _____

Address if Different than Patient: _____

Secondary Insurance Information

Secondary Insurance Name: _____ __

Policy#: _____ _____Group#: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthday: _____ SSN: _____

Address if Different than Patient: _____

This document will be considered valid unless a written revocation is received.

Please read, review the disclaimer and sign at the bottom stating you acknowledge and agree to the terms:

Authorization, Assignment and Responsibility of Account

- The Patient/Guarantor is responsible for payment in full of all services rendered by staff members of Tennessee Valley Family Care.
- The copay is to be paid in full at the time of service. No exceptions. Any other necessary financial arrangements must be made prior to service.
- I hereby authorize Tennessee Valley Family Care, to release to any insurance company and/or other intermediaries and/or carriers of any medical or other information needed for claims reimbursement.
- I hereby assign, transfer and set over to Tennessee Valley Family Care, all my rights, title and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies.
- I hereby acknowledge and accept responsibility for payment in full for any and all services rendered to me by Tennessee Valley Family Care.
- There will be a $25 charge on all returned checks and/or delinquent accounts which must be paid.
- Non-payment of accounts within 60 days will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection cost of 40% incurred to collect outstanding accounts will be the patient's responsibility.
- I hereby acknowledge Tennessee Valley Family Care to perform a Pharmacy Check if warranted.
- I hereby acknowledge receipt of the Notice of Privacy Practices given to me by Tennessee Valley Family Care.
- I understand that if I am 15 minutes late for an appointment, said appointment will be rescheduled as time slots are available. I accept responsibility for any delay of medical treatment realizing this includes possibly doing without prescribed medication or having to make emergency room visits. If two (2) visits are rescheduled due to tardiness and/or 3 No Show appointments, Tennessee Valley Family Care Administration and providers may take it under advisement whether or not to dismiss me as a patient.

_____ _____ _____

Print Name of Patient/Guardian Signature of Patient/Guardian Date

Consent of Release of Patient Health Information

Patient's Name: _____ Date of Birth: _____

Please list any individuals that Tennessee Valley Family Care can release any patient information to. Examples of patient information but not limited to are appointment, referrals, test results, treatment, medication Information and/or billing Information.
Also include any individuals that are allowed to **give care to the minor patient** if parent/ guardian are not present. Please **include all step parents** if parents are separated.

Some form of ID is required at check in to identify individuals.

☐ **I do not wish to list anyone for Tennessee Valley Family Care to release any patient information to and/or to give care to my child without me being present.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Print Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Relationship (If patient is minor): _____

Date: _____

Tennessee Valley Family Care

Stephanie D. Tucker MSN, FNP-C Elizabeth R. Phillips FNP-C and Kathy E. Cohen FNP-C

Patient Demographics

Text Messaging Consent and Disclaimer

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

Your health care is important to us. In order to provide you with the best possible care, we can send convenient text messages to our patients about their health care, appointments, questions or other information.

Tennessee Valley Family Care uses the program NUSO as one of our means of electronic communication. You may send to and receive messages from our office phone number 931-363-2925. Please be aware text messages through this phone number do not provide security of patient information.

We will only communicate with the cell phone number(s) listed below:

_____.

If you wish to communicate through a different cell phone number in the future, you will have to sign an updated Text Messaging Consent and Disclaimer before any electronic communication is conducted through the NUSO system.

Please do not enclose any patient/personal information, for example Date of birth, SS#, etc., in order to protect your patient health information in your text messages.

If you need to contact us about an urgent matter that is not an emergency please DO NOT send our office a text message or wait for a text message reply. Please call our office immediately at 931-363-2925. DO NOT rely on electronic communication or communications for immediate, urgent or medical needs. This electronic submission is not designed to facilitate medical emergencies.

If we do not respond back immediately, please allow at least 1 business day for a response.

- I have read and understand Tennessee Valley Family Care's Text Messaging Consent and Disclaimer.
- I understand that Tennessee Valley Family Care uses NUSO as one of their electronic communications program and I am aware that is not a secure program for PHI (patient health information). I release Tennessee Valley Family Care from any liability if there was a system breach of the computer program.
- I understand that Tennessee Valley Family Care may ask a minimal amount of my patient information for verification that they are communicating with me for HIPPA purposes. I have the right to request a restriction on certain uses and disclosures of my health information. I understand that I have the right to opt out this consent in writing. I acknowledge Tennessee Valley Family Care will not be able to delete any communications that were made prior to signing new consent form opting out of the NUSO program.

☐ I consent to such use of the program and agree to the terms.

OR

☐ I Wish to OPT OUT of the use of the program and wish to only do electronic communication through Tennessee Valley Family Care EMR system e-ClinicalWorks/Healow/patient portal.

Patient/Legal representative Name Print: _____**Relationship:**_____

Patient/Legal representative Signature: _____

Date: _____

Tennessee Valley Family Care

Health Information consent and Acknowledgement of Notice of Privacy Practice.

Please read and initial by each bullet and sign and date at bottom.

- _____Copays are due at the time of check in.

- _____A payment of $50 will be required at the time of check in for patients that have a deductible or high coinsurance for PCP office visits.

- _____A payment of $20 will be required at the time of check in for patients that have a coinsurance for PCP office visits.

- _____If you have a balance, a payment of $25 per $100 your balance shows is required at the time of check-in. For Example, if balance is $330, a payment of $75 is required.

- _____ A payment of $25 per $100 your balance shows is required in order to receive your narcotic script.

- _____ There is no exceptions! If you are not able to pay when picking up script, you will not be able to get it filled and if you are not able to pay at time of check in, you will have to reschedule appointment.

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

Guardian/Legal representative: Name: _____

Patient/Legal representative Signature: _____ **Date:** _____

Tennessee Valley Family Care

Health Information consent and Acknowledgement of Notice of Privacy Practice.

Consent of medical treatment:

I hereby consent to the rendering of medical care which may include diagnostic procedures, medical treatment, and possible hospital admission as considered necessary by the medical providers of Tennessee Valley Family Care and members of their office staff.

Release of Health Information:

I authorize that my health information may be released to requesting insurance companies and/or other physicians or medical facilities. This includes medical history, mental and physical condition, diagnoses, prognoses treatment, x-ray, lab results, and other test results.

I understand that Tennessee Valley Family Care uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations including administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use of disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Tennessee Valley Family Care's notice of information practices for more information about how my protected health information may be used and disclosed. I understand that Tennessee Valley Family Care may change its information practices, but before doing so, a new notice will be posted in the waiting area and each examination room. I may also call Tennessee Valley Family Care's phone number (931)-363-2925 at any time to request a copy of the notice of information practices.

I understand that I have the right to request a restriction on certain uses and disclosures of my health information. Tennessee Valley Family Care is not required to agree to such restrictions, but if Tennessee Valley Family Care does agree, it must abide by those restrictions. I understand that I have the right to revoke this consent in writing, except where Tennessee Valley Family Care has already made disclosures in reliance on my prior consent.

Payment:

Payment is required at the time of service. Tennessee Valley Family Care will provide all the information needed to file my insurance. I understand that I am directly and fully financially responsible to Tennessee Valley Family Care for charges not covered by my insurance. I further understand that such payment is not contingent with any settlement, judgment, or insurance payments by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days; It's my responsibility to pay doctor bills directly.

Insurance Payment:

I hereby authorize Tennessee Valley Family Care to bill my insurance company directly for their services. I request that payment of insurance benefits be made on my behalf to Medical Providers of Tennessee Valley Family Care unless payment is made at the time of service. I understand that regardless of the assignments of benefits or what type of insurance coverage I have I am responsible for any and all charges incurred by myself or my dependents. I also agree to pay Tennessee Valley Family Care the part of the fee which is not covered by my insurance plan. In the event I received payment from my insurance carrier, I agree to endorse any payment I receive over to Tennessee Valley Family Care to whom these fees are payable.

I instruct my doctor to complain on my behalf to the insurance commissioner, if he deems it necessary. I have received and read a copy of the notice of privacy practice of Tennessee Valley Family Care.

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

Guardian/Legal representative:

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

Patient/Legal representative Signature: _____ **Date:** _____

Tennessee Valley
Family Care

1150 East College St
Pulaski, TN 38478
Phone (931) 363-2925
Fax (931)-363-9563

RELEASE OF INFORMATION AUTHORIZATION

Provider/Facility information:

_____

_____

_____

Provider receiving information
Kathy Cohen, MSN, FNP-C
Elizabeth Phillips, MSN, FNP-C
Stephanie Tucker, MSN, FNP-C

- ✓ Name of Patient: _____
- ✓ Date of Birth: _____

Records Requested: _____

I authorize the release of medical records as described above:

- ✓ Print Name: _____

- ✓ Signature: _____

Relationships (if patient is a minor): _____

Date: _____

Patient History

Patient Name: _____ DOB: _____ Date: _____

Reason for visit: _____

Medications: List all medications you are currently taking:

Name Of Medication	Strength	How often taken

Past Medical History

Please mark any of the conditions you have had. O None

O Aids	O Chemical Dependency	O Heart Disease	O Liver Disease
O Alcoholism	O Diabetes	O Hypertension	O Migraine Headaches
O Arthritis	O Emphysema	O Hepatitis	O Multiple Sclerosis
O Asthma	O Epilepsy	O High Cholesterol	O Pacemaker
O Breast Lumps	O Glaucoma	O HIV Positive	O Prostate Problems
O Bleeding Disorders	O Goiter	O Kidney Disease	O Psychiatric Care
O Stroke	O STD's	O Suicide Attempt(s)	O Thyroid Problems

Other: _____

Do you have any history of any Cancers? Yes No (If yes please fill out below)

- **Type of Cancer:** _____ **Current or Remission**
- **Type of Cancer:** _____ **Current or Remission**

Allergies: Please list all allergies, if any and what kind of reaction:

Allergy	Reaction

Surgical History

Have you had any surgeries? Yes No **(If yes, please fill in the sections below)**

Month/Year	What kind of surgery	Facility/Location

Hospitalization

Have you ever been hospitalized? Yes No **(If yes please fill in the sections below)**

Month/Year	Hospitalized for	Facility/Location

Patient History

For Women only:

Birth Control:

1. Are you currently on any birth control medication or have a device inserted? Yes No
   - ◊ If yes, what's the name? _____
   - ◊ What pharmacy last filled it? _____
   - ◊ Date last dose taken:_____
2. Are you doing any other form of birth control?(ex: condoms) Yes No
   - ◊ If yes, what else are you doing to prevent pregnancies? _____

Menstrual Periods:

1) Do you still currently have cycles? Yes No

If yes, please fill in below.

Date of last Period	Length of Cycle	Regular or Irregular Cycle?

1) Date of last pap smear: _____ Was pap smear: Normal Abnormal
   - ◊ What Providers office did you have your last pap smear?
     - o Facility Name: _____
     - o Provider: _____
     - o Address: _____
     - o Phone #: _____

2) Date of last mammogram: _____ Was mammogram: Normal Abnormal
   - ◊ Facility Name: _____
   - ◊ Address: _____
   - ◊ Phone #: _____

Pregnancies:

Year Of Birth	Sex of Birth	Type of Delivery/Any Complications
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	

Patient History

Family History

Is your Father? Living What is their **year** of birth and current age? _____
Deceased What was their age when they passed? _____
What was the cause of death? _____

Does your **Father** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer) _____
O Other health issue: _____

Is your Mother? Living What is their **year** of birth and current age? _____
Deceased What was their age when they passed? _____
What was the cause of death? _____

◆ Does your **Mother** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer): _____
O Other health issue: _____

Is your Brother(s)? Living What are their **year** of births and current ages? _____
Deceased What was their age/ages when they passed? _____
What was the cause of death? _____

◆ Does your **Brother(s)** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer) _____
O Other health issue: _____

Is your Sister(s)? Living What are their **year** of births and current ages? _____
Deceased What was their age/ages when they passed? _____
What was the cause of death? _____

◆ Does your **Sister(s)** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer) _____
O Other health issue: _____

Do you have any children? No Yes (How Many biological? _____ How many not biological? _____)

Is your Daughter(s)? Living What are their **year** of births and current ages? _____
Deceased What was their age when they passed? _____
What was the cause of death? _____

◆ Does your **Daughter(s)** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer) _____
O Other health issue: _____

Is your Son(s)? Living What are their **year** of births and current ages? _____
Deceased What was their age when they passed? _____
What was the cause of death? _____

◆ Does your **Son(s)** have history of: O None O Diabetes O Heart Disease O Hypertension
O Cancer (Form of cancer) _____
O Other health issue: _____

Social History

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Social History for Adult ONLY (age 18 and above)

Is someone designated as a health care power of attorney? O Yes O No

- If yes, Who? _____

Do you drink caffeine? O None O Daily O Weekly O Monthly O Other

- If yes, What kind of caffeine? _____ How much per day? _____

Do you exercise? O Yes O No

- If yes, Type of exercise? _____How often? _____How long? _____

Sexually Active? O Yes O No

- If yes, do you use protection? ____ __What form? _____

Do you do Chewing tobacco? O Yes O No

Are you a Current, Former or Nonsmoker?

O Non Smoker O Current O Former O Use smokeless tobacco product

- If you are a **former smoker**, please answer following questions?
  - How long ago did you stop smoking? _____
  - How much did you smoke a day? _____

- If you are a **current Smoker**, please answer following questions:
  - How often do you smoke? O Every Day O Some Days but not every day
  - How much do you smoke a day? _____

How soon after you wake up do you smoke your first cigarette? _____

Marital Status O Single O Married O Divorced O Separated O Widowed

Occupation O Full Time O Part Time O Retired O Unemployed O Disabled

How many children do you have? _____

Do you wear your seatbelt? O Yes O No

Do you have vision or hearing loss? O Yes O No

Can you read and/or write? O Read and Write O Read Only O Write Only O Neither

Have you given shared needles, obtained a tattoo? O None O Obtained a Tattoo O Shared Needles

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NATIONAL ASSOCIATION OF Community Health Centers | AAPCHO | OPCA Oregon Primary Care Association | Institute for Alternative Futures

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE for Implementation As of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question

2. Which race(s) are you? Check all that apply.

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question

5. What language are you most comfortable speaking?

☐	English
☐	Language other than English (please write)
☐	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question

7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

9. What address do you live at?

Street:_____

City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance		

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact us at mjester@nachc.org.

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13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
		I choose not to answer this question			

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question

19. Are you a refugee?

	Yes		No		I choose not to answer this question

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

Patient History

Alcohol Screening-for 18 years and older

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never (0 point)

☐ Monthly or less (1 point)

☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points)

☐ 4 or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point)

☐ 3 or 4 drinks (1 point)

☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points)

☐ 10 or more drinks (4 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Depression Screening: for 18 years and older

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Patient History

For Ages 18 and above only for Fall Risk Questionnaire:

Fall Risk Assessment: Please circle Y (Yes) or N(no) for each of the following questions:

Y N 1. Have you fallen in the past year?

Y N 2. Do you use a cane or walker?

Y N 3. . Do you feel unsteady when you are walking?

Y N 4. Do you steady yourself by holding onto furniture?

Y N 5. Do you worry about falling?

Y N 6. Do you push with your hands to stand up from a chair?

Y N 7. Do you have some trouble stepping onto a curb?

Y N 8. . Do you often have to rush to the toilet?

Y N 9. Have you lost some feeling in your feet?

Y N 10. Do you take medicine that sometimes makes you feel light headed or more tired than usual?

Y N 11. 11Do you take medicine to help you sleep or improve your mood?

Y N 12. Do you often feel sad or depressed?

For Ages 18 and above only to answer for Routine Task:

Routine Tasks: Please circle any tasks you need help performing and who helps complete them

Feeding yourself	Getting from bed to chair	Getting to the bathroom	Getting dressed
Bathing	Walking across the room	Using the telephone	Taking medications
Preparing meals	Managing money (e.g., paying bills)	Housekeeping	Shopping
Driving	Climbing stairs	Laundry	Yard work

Who assists with these tasks?

_____

Patient History

For Ages 18 and above only to answer for Pain assessment:

Pain Assessment:

Do you suffer from pain? _____ Are you in pain management? _____

Where is your pain? _____

How would you rate the pain?

- ☐ No pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain
- ☐ Extreme pain

For ages 3 yrs old and older only answer Hearing Questionnaire :

Please circle either Y (yes) or N (no) for each question.

1.	Do you find it difficult to follow a conversation in a noisy room?	Y	N
2.	Do you find yourself asking people to speak up or repeat themselves?	Y	N
3.	Do you find men's or women's voices easier to understand?	Y	N
4.	Do you have difficulty understanding speech on the telephone?	Y	N
5.	Do you experience ringing or noises in your ears?	Y	N
6.	Do you hear better with one ear than the other?	Y	N
7.	Have you had any significant noise exposure?	Y	N

For all ages: Please answer questions below if you have had any of the vaccines or procedures? If yes please list date and where it was given/done at.

- ☐ **Flu Vaccine:** _____
- ☐ **Pneumoccal Vaccine:** _____
- ☐ **Tdap/Tetanus Vaccnine:** _____
- ☐ **Hep B Vaccine:** _____
- ☐ **HPV Vaccine:** _____
- ☐ **Shingles Vaccine:** _____
- ☐ **Mammogram:** _____
- ☐ **Colonoscopy:** _____
- ☐ **Retinal or diabetic eye exam :** _____
- ☐ **Had a fracture of a bone other than a finger, toe, face, or skull? (circle one) Yes No**

Social History

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Please circle either Y (Yes) N (No) for each question:

1) Have you ever had TB (Tuberculosis)? Y N
2) Have you been living with anyone in the past 2 years who has been diagnosed with TB? Y N
3) Have you had a persistent cough and fever more than 2 weeks? Y N
4) Have you had a persistent cough and night sweats for more than 2 weeks? Y N
5) Have you had a persistent cough and loss of appetite for me than 2 weeks? Y N
6) Have you been coughing up or spitting up bloody sputum (saliva)? Y N
7) Have you ever had a blood transfusion? Y N (If yes, please give approximate date: _____)

Nutrition

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup =size of a baseball.)

_____ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

_____ servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

_____ servings per day

In the past 7 days, how many *sugar-sweetened* (not diet) beverages did you typically consume *each day*?

_____ sugar sweetened beverages consumed per day

☐ List anyone who lives with you in your household:

_____

_____

☐ Do you have any pets? If yes please put what kind and if they are indoor or outdoor pets.

_____

_____

Patient History

For 18 years and older please answer the following questions:

Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

❒ Almost all of the time
❒ Most of the time
❒ Some of the time
❒ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

❒ Almost all of the time
❒ Most of the time
❒ Some of the time
❒ Almost never

High Stress

How often is stress a problem for you in handling such things as:
–Your health?
–Your finances?
–Your family or social relationships?
–Your work?

❒ Never or rarely
❒ Sometimes
❒ Often
❒ Always

Social/Emotional Support

How often do you get the social and emotional support you need:

❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never

General Health

- In general, would you say your health is?
  ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

- How would you describe the condition of your mouth and teeth—including false teeth or dentures?
  ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

Sleep

- Each night, how many hours of sleep do you usually get? _____ hours
- Do you snore or has anyone told you that you snore? ❒ Yes ❒ No
- In the past 7 days, how often have you felt sleepy during the daytime?
  ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never

Current Symptoms

Please answer yes or no if you have had any of these symptoms in the **last 30 DAYS.**

Please mark answer by filling in bubble. For example ◉ Yes ○ No. Please DO NOT mark X, /, or ✓

Allergy/Immunology

Runny Nose	O Yes	O No
Cough	O Yes	O No
Sneezing	O Yes	O No
Wheezing	O Yes	O No

Psychiatric

Anxiety	O Yes	O No
Depressed mood	O Yes	O No
Difficulty sleeping	O Yes	O No
Substance abuse	O Yes	O No
Suicidal thoughts	O Yes	O No

Skin

Acne	O Yes	O No
Eczema	O Yes	O No
Itching	O Yes	O No
Changes in Mole(s)	O Yes	O No
Rash	O Yes	O No

Cardiovascular

Chest pain	O Yes	O No
Dizziness	O Yes	O No
Irregular heartbeat	O Yes	O No
Shortness of breath	O Yes	O No
Weakness	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No
Painful urination	O Yes	O No

ENT

Difficulty swallowing	O Yes	O No
Ear pain	O Yes	O No
Nosebleed	O Yes	O No
Ringing in the ears	O Yes	O No
Sinus pain	O Yes	O No
Sore throat	O Yes	O No

Men Only

Difficulty initiating stream	O Yes	O No
Dribbling after urination	O Yes	O No
Penile discharge	O Yes	O No
Rash or blisters on penis	O Yes	O No
Scrotal pain	O Yes	O No
Scrotal swelling	O Yes	O No

Women Only

Breast lump	O Yes	O No
Breast pain	O Yes	O No
Discharge from the breast	O Yes	O No
Heavy bleeding during menses	O Yes	O No
Hot flashes	O Yes	O No
Irregular menses	O Yes	O No
Missed periods	O Yes	O No
Painful intercourse	O Yes	O No
Painful menses	O Yes	O No
Vaginal discharge/itching	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No
Blood in stool	O Yes	O No
Change in bowel habits	O Yes	O No
Constipation	O Yes	O No
Decreased appetite	O Yes	O No
Diarrhea	O Yes	O No
Exposure to hepatitis	O Yes	O No
Heartburn	O Yes	O No
Nausea	O Yes	O No
Rectal bleeding	O Yes	O No
Vomiting	O Yes	O No
Weight loss	O Yes	O No

General/Constitutional

Change in appetite	O Yes	O No
Chills	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Headache	O Yes	O No
Lightheadedness	O Yes	O No
Night sweats	O Yes	O No
Sleep disturbance	O Yes	O No
Weight gain	O Yes	O No

Musculoskeletal

Back pain	O Yes	O No
Joint stiffness	O Yes	O No
Pain in shoulder(s)	O Yes	O No
Painful joints	O Yes	O No
Weakness	O Yes	O No

Patient History

Please list all providers (PCP (primary care provider), Specialist, etc) that you have previously seen.

Name Of Provider	Provider's Specialty or PCP	City	State	Phone Number

Patient History

Please list all Other Specialty Practitioners You See:

O **Do Not see any specialty Providers**

Provider's Name	City	Phone Number	Reasoning for seeing provider:

All patients please read and sign below if in agreement.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of the Current Symptom and Patient History forms.

Print name of Patient/Legal Guardian: _____

Signature Of Patient/Legal Guardian: _____Date_____