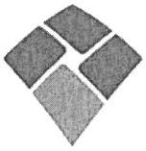

Cheyenne Regional
Medical Center

Behavioral Health Services
2600 E. 18th St.
Cheyenne, WY 82001
307-633-7382 Phone
307-633-7202 FAX

New Patient Packet
Telehealth

- Please complete the New Patient packet and return by fax. The front desk team will contact you to schedule an appointment after reviewing your completed new patient packet.
- Please arrive to your first appointment 15 minutes early so that your vital signs can be obtained. If your telehealth site does not provide vitals, you will have to obtain them the day of your first appointment. Vitals include height, weight, blood pressure, and heart rate.
- If any information is missing or incomplete, a member of the nursing team will contact you with any questions or to clarifying any information.
- Insurance required Co-Pays can be paid by check and mailed, or by credit card over the phone prior to the time of service.

New Patient Packet Checklist:

- Patient Registration forms
- Consent for Treatment form
- Consent for Teleheatlh form
- Release of Information form
- No Show Policy form
- Medicare Questionnaire forms
- Patient Screening
- PHQ-9

Please include:

- Photocopy of your photo ID.
- Photocopy of your insurance card(s).
- Guardianship paperwork if appropriate.
- Referring provider and or behavioral health records if available.

******Please fax completed packet to 307-633-7202. Please keep in mind any incomplete section my result in delay of care.***

Patient Registration Form

Cheyenne Regional Medical Center

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name *First Name* *Middle Initial*

Sex ☐ Male ☐ Female Date of Birth: _____ Aliases: _____

Street Address/City/State/Zip _____

Mailing address (if different than above) _____

Home Phone ( ) _____ Cell Phone ( ) _____ Can we leave messages? ☐ Yes ☐ No

E-mail address _____

Interpreter Needed? ☐ Yes ☐ No

Marital Status ☐ Divorced ☐ Legally Seperated ☐ Married ☐ Single ☐ Widowed ☐ Other _____

Ethnicity: ☐ American Indian ☐ Hispanic or Latino ☐ Patient Refused ☐ Unknown ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White or Caucasian

☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Patient Refused ☐ Unknown

Primary Language ☐ English ☐ Spanish ☐ Other _____ Religion: _____

Primary Care Provider: _____

Address: _____

Phone Number: _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Additional Contact _____ Phone ( ) _____ Relationship _____

Employer: _____

Address: _____

Phone Number: _____

Employment Date: (From) _____ (To) _____

Status: ☐ Disabled ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

Guarantor (Party Responsible for Bill) ☐ Self ☐ Employer ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name: _____ SSN#: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Cheyenne Regional Medical Center

Patient Registration Form

INSURANCE INFORMATION

Primary Insurance _____

ID # _____ Group # _____

Telephone ( ) _____

Insured Name _____

Insured DOB _____ Sex ☐M ☐F

Relationship to Patient: _____

Secondary Insurance _____

ID # _____ Group # _____

Telephone ( ) _____

Insured Name _____

Insured DOB _____ Sex ☐M ☐F

Relationship to Patient: _____

Third Insurance (if any) _____

**** A copy of your insurance card and photo ID is required for billing****

If this is a Workman's Comp/Injury (more information may be requested)

Date of Injury _____

Docket/Claim number _____ Contact Person _____

I acknowledge that I have been given the right to review and secure a copy of the Notice of Privacy Practices. I understand that the organization reserves the right to change the terms of this notice._____ (Initial)

_____

Signature of Patient/Guardian Date

Cheyenne Regional Medical Center

STAMPER OR PATIENT LABEL

CONSENT FOR TREATMENT

HEALTH AND MEDICAL CARE CONSENT: I give my consent to all healthcare services performed by Cheyenne Regional Medical Center its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my attending physician or surgeon, his/her assistants, or his/her designees. Cheyenne Regional Medical Center conducts training programs for health care professionals. These persons may be observing or participating in Cheyenne Regional Medical Center's treatment programs. They will be under the direct supervision of licensed professionals. I understand that I have the right to refuse to have trainers participate at any time, in my care.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN: I understand that all the physicians furnishing services to me, including the emergency room physician, on-call physician, radiologist, pathologist, and anesthesiologist are independent practitioners and unless otherwise indicated, are not employees or agents of Cheyenne Regional Medical Center. I understand that my relationship with my treating physicians is initiated, continued, and/or changed by me and is at my discretion. These providers may bill separately for their services and may not be covered by your insurance.

RELEASE OF INFORMATION AND INSURANCE BENEFITS: I authorize Cheyenne Regional Medical Center and my physician to release my medical and/or financial records to individuals and entities as specified in the Notice of Privacy Practices and/or by federal and state law. I understand that Cheyenne Regional Medical Center may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months unless I revoke it, in writing. I understand that any revocation will not be effective for disclosures necessary to effectuate payments for health care that has been provided.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I authorize and assign direct payment of insurance benefits to Cheyenne Regional Medical Center and physicians involved in my care for all amounts due from my primary and/or supplemental insurance carrier(s). I understand and agree that I am financially responsible for payment of any charges which insurance does not pay. I further understand, lacking timely payment by my insurance, I will be required to assume responsibility for payment of my account. If financial assistance is requested for payment of my account, I hereby give my permissions for investigation of my credit including a receipt of my consumer report from a consumer reporting agency. I understand that services are provided to me, the patient, and not my insurance company. I understand and agree that I am totally responsible for payment of all Cheyenne Regional Medical Center charges and the fees of other professional providers for care rendered to me at Cheyenne Regional Medical Center. If my bill is not paid in full thirty (30) days from the date services are provided, I understand finance charges may be added at the rate of 1% per month, or 12% per year. I agree to be responsible for all attorney fees and court costs in collecting any sums due and owing for services received.

PERSONAL VALUABLES: I understand and agree that Cheyenne Regional Medical Center shall not be liable for loss or damage to personal property not deposited in the hospital safe. Cheyenne Regional Medical Center reserves the right to inventory items placed in the safe, to refuse to accept items, and to dispose of items after my discharge if unclaimed thirty (30) days after written notice is mailed to my last known address.

ACKNOWLEDGEMENTS (PATIENTS TO INITIAL EACH ACKNOWLEDGEMENT, IF APPLICABLE):

_____ I acknowledge receipt of the **Notice of Privacy Practices** _____ (Date Given)
_____ I acknowledge receipt of the **Patient Bill of Rights and Responsibilities**
_____ I acknowledge receipt of the **Medicare/TriCare Patient Rights and Responsibilities, and reminded of the Important Message from Medicare**
_____ I provided my **Ethnicity, Race and** what language I prefer to receive for medical or healthcare instructions.

☐ **Yes, My name, facility location and my religious affiliation will be included in the Facility Directory.**
☐ **NO, Facility Directory OPT-OUT:** I object to having information related to me included in the Facility Directory while I am receiving outpatient service and/or hospitalized for this visit. It is my wish that the following information (indicated by patient initials) not be included in the Facility Directory:

Information about myself including my name and location in the facility. This Means:
(a) If a relative, friend, or community clergy calls and asks for you by name, they will be told "We have no information on that person."
(b) If flowers, gifts or mail are delivered, they may be refused and returned.

My Religious affiliation. This Means:
(a) Your name may not be on the list that may be provided to community clergy, hospital trained volunteer, Eucharistic and lay ministers.

I have read this form and understand its contents. I have had an opportunity to ask questions, which have been answered to my satisfaction.

_____ _____
Patient Signature **Date/Time**

_____ _____
Signature of Authorized Representative/Parent/Guardian **Date/Time**

_____ _____
Signature of Witness **Date/Time**

_____
Patient Address

Cheyenne Regional Medical Center

Child & Adolescent/Adult Behavioral Health Clinics
Informed Consent for Telehealth Consultations

STAMPER OR PATIENT LABEL

2600 E 18th St
Cheyenne Wy 82001
Phone: 307-633-7370
Fax: 307-633-7202

For convenience and cost-efficiency, behavioral health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth," this means that you may be evaluated and treated by a health care provider or specialist from a different location. Since this is different than the type of consultation with which you are familiar, **you must certify that you understand and agree to the following:**

1. The consulting health care provider or specialist ("Specialist") will be at a different location from me. A physician or other health care provider ("Presenting Practitioner") will be at my location with me to assist in the consultation.
2. The Presenting Practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.
3. Details of my medical history, examinations, medications, x-rays, and tests will be discussed with the specialist who is at a different location.
4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and Presenting Practitioner. I will give my verbal permission prior to additional personnel being present.
5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording.
6. The Presenting Practitioner for whom the on-site examination or treatment is performed will keep a record of the consultation in my medical record. The Specialist shall also keep a record of the consultation.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary.

RELEASE OF INFORMATION: All existing laws regarding access to your medical information and copies of your medical records, including the Health Insurance Portability and Accountability Act (HIPAA) and apply to this telehealth consultation. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent.

I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the Presenting Practitioner refrain from transmitting my information if I make the request before the information is transmitted.
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off-site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Patient: _____ Date: _____ Time: _____
(PLEASE SIGN)

Patient Representative: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

Patient name: _____

Provider: _____

Location: _____

Please FAX signed form to 307-633-7202 and place original in patient's record.

Cheyenne Regional

Authorization to Release Health Care Information and/or Behavioral Health Care Information

Health Information Management
Cheyenne Regional Medical Center
214 East 23rd Street Cheyenne, WY 82001;
Fax (307) 432-3108.
Phone (307) 633-7925

(1) Patient

Name	Previous Name(s)
Birth Date	Phone Number

(2) Information Released FROM

☐Cheyenne Cardiology Associates ☐ Cheyenne Children's Clinic ☐ Cheyenne Family Medicine ☐Cheyenne Plaza
☐Consultant In Surgery ☐Wyoming Neurology ☐ Hospice☐ Wyoming Orthopedics ☐ Weight Loss ☐ Urgent Care
☐BHS ☐ Cheyenne Regional Medical Center ☐ *Inpatient* ☐ *Outpatient*

Other Clinic/Provider:

Address	City	State	Zip Code

(3) Information Disclosed TO

Individual/Facility/Organization:

Attn/Dept:	Phone Number		Fax
Address	City	State	Zip Code

Information to be released by: ☐ Paper ☐ CD containing information **FROM:** _____ **TO:** _____ include:

(4) Health Information to be Released

Provider Dictation/Notes	Diagnostics	Miscellaneous	Miscellaneous Continued
☐ MD Notes	☐ Echo(s)	☐ Progress Notes	☐ Radiology Images (CD)
☐ ER/Urgent Care Record	☐ EKG/Tracings	☐ Immunizations	☐ Billing Information
☐ History & Physical(*)	☐ LAB(s)	☐ Medications	
☐ Consults(*)	☐ Pathology Reports	☐ HIV test results	☐ Abstract Record (includes *)
☐ Operative/Proc Note(*)	☐ Radiology Reports(*)	☐ Treatment Plans	☐ Complete Record for locations
☐ Discharge Summary(*)	☐ EEG Reports	☐ Nursing Records	listed in Box 2 above
☐ Psych Eval	☐ Sleep Studies		
☐ BH Evals/Assessments			

Other (please specify) _____

(5) Purpose for Disclosure

☐ Personal ☐ Continuity of Care ☐ Worker's Comp ☐ Insurance ☐ Disability ☐ Legal

Other _____

(6) Delivery Method

*There may be a charge/fee for copies of records. **Information needed by:** _____

☐ FAX ☐ MAIL ☐ PICK UP BY Patient or Designee _____

(7) Authorization

I hereby authorize Cheyenne Regional to release the health information indicated above that is contained in my patient record to the Recipient named above. I understand and acknowledge the release to include by initialing:
_____**Treatment for physical and mental illness** _____ **Alcohol/drug abuse** _____**HIV/AIDS test results or diagnoses.**
This authorization does not include permission to release outpatient Psychotherapy Notes as defined as notes that document private, group, or family counseling sessions that are separated from the rest of a patient's medical record. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the recipient may no longer be protected by law.

_____ _____

Signature Date (Expires one year from signature date)

(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

_____ _____

Relationship to Patient (if not patient) Expiration Date

Cheyenne Regional

Authorization to Disclose Health Information to Family or Other

STAMPER OR PATIENT LABEL

Patient's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

I here by authorize Cheyenne Regional Medical Group to disclose health information to the following contact(s):

Contact #1

Name: _____ Relationship to me: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Contact #2

Name: _____ Relationship to me: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

By signing this form I understand that Cheyenne Regional Medical Group may discuss past, present, or future health care issues with these contacts from _____ (Start) through _____ (End)

The information that may be disclosed or discussed is:

_____ All my information (except HIV, mental health, and substance abuse)

__✓__ HIV, mental health, and substance abuse information (please specify)

Signature: _____ Date: _____

You may revoke this authorization at any time. Please note that cancellation by telephone must be confirmed in writing. However, your revocation will not affect any use or discloser that you permitted, and that was made prior to your revocation.

Cheyenne Regional Medical Center Behavioral Health Services

Patient No Show Policy

We at CRMC-BHS want to support our patients to keep their established appointments in order to help ensure that they receive excellent care. However, when our established patient's do not attend scheduled appointments, another member of the community has missed an opportunity to access treatment. Please keep the following guidelines in mind:

A. When patients are unable to keep their appointment, they will need to notify the clinic staff, or leave a message at least 24 hours in advance of scheduled appointment. CRMC-BHS may automatically charge a "No-Show" fee to the patient and/or responsible party if this expectation is not met. Please keep in mind, insurance companies will not cover these fees. With unavoidable emergencies there may be no charge. **You can reach the clinic by calling (307) 633-7370 or (307) 633-7382.**
B. If a patient is rescheduled from a no-show appointment or a late cancellation, staff will explain the expectation that the no-show fee will be paid alongside any co-pay required at the subsequent appointment.
C. If a patient has **two** no-show appointments in a **three** month period we will send a termination of treatment letter by registered mail and an invitation to petition for return for treatment by provider agreement. At this time, all future appointments with your Provider will be cancelled.
D. If you would like to resume services or petition for return to treatment, please contact our Clinic Manager to discuss your unique circumstances. Keep in mind, once services have been closed you may be placed back on a waitlist before resuming services. If required, the Psychiatrist will assist in tapering medications.
E. In the case of a telepsychiatry appointment, if the cause for a missed appointment is due to technical failure of equipment on either party's end there will not be a "No Show" charge.

I have been informed of the above procedures.

_____ _____

Signature of patient or Guardian Date

_____ _____

Print Name Date of Birth

MEDICARE MSP QUESTIONNAIRE

NAME: _____ DATE: _____

- Are you currently active with a home health care agency?
  □YES □NO Name of Agency: _____ Dates of Service:_____

PART I

1. Are you receiving Black Lung (BL) Benefits?
   _____ Yes Date benefits began: **MM/DD/YYYY**; BL is primary only for claims related to BL.
   _____ No

2. Are the services to be paid by a government *research* program?
   _____ Yes Government program will pay primary benefits for these services.
   _____ No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for *your* care at this facility?
   _____ Yes DVA is primary for these services.
   _____ No

4. Was the illness/injury due to a work-related accident/condition?
   _____ Yes Date of injury/illness: **MM/DD/YYYY**
   Name and address of WC plan: _____
   Policy and identification number: _____
   Name and address of your employer: _____
   WC is primary payer only for claims forms work-related injuries or illness.
   Go to Part III.
   _____ No **Go to Part II.**

PART II

1. Was illness/injury due to a non-work-related accident?
   _____ Yes Date of accident: **MM/DD/YYYY**
   _____ No Go to Part III.

2. What type of accident caused the illness/injury?
   _____ Automobile Name and address of No-fault or Liability insurer:
   _____
   Insurance Claim Number: _____
   No-fault insurer is primary payer only for those claims related to the accident. Go to Part III.
   _____ Non-automobile
   _____ Other

3. Was another party responsible for this accident?
   _____ Yes Name and address of any Liability insurer: _____
   Insurance Claim Number: _____
   Liability insurer is primary only for those claims related to the accident. Go to Part III.
   _____ No **Go to Part III.**

PART III

1. Are you entitled to Medicare based on:
   _____ Age **Go to Part IV.**
   _____ Disability **Go to Part V.**
   _____ End-Stage Renal Disease (ESRD) **Go to Part VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "Parts" associated with the patient's selections.

PART IV – Age

1. Are you currently employed?
   _____ Yes Name and address of your employer: _____
   _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   _____ No *Never Employed*

2. Is your spouse currently employed?
   _____ Yes Name and address of spouse's employer: _____
   _____ No *If applicable, d*ate of retirement: **MM/DD/YYYY**
   _____ No *Never Employed*

If patient answered "NO" to both questions 1 and 2, Medicare is primary unless patient answered "YES" to questions in Part I or II. Do not proceed any further.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?
   _____ Yes, *both*
   _____ Yes, *self*
   _____ Yes, *spouse*
   _____ No **Stop. Medicare is primary payer unless the patient answered yes to the questions in Part I or II.**

4. *If you have GHP coverage based on your own current employment,* does your employer that sponsors, or contributes to the GHP employ 20 or more employees?
   _____ Yes **Stop. GHP is primary. Obtain the following information.**
   Name and address of GHP: _____
   Policy identification number: _____
   Group identification number: _____
   Name of policy holder: _____
   Relationship to patient: _____
   _____ No **Stop. Medicare is primary payer unless the patient answered yes to questions in Part I or II.**

5. *If you have GHP coverage based on your spouse's current employment,* does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?
   _____ Yes **Stop. GHP is primary. Obtain the following information.**
   Name and address of GHP: _____
   Policy identification number: _____
   Group identification number: _____
   Name of policy holder: _____
   Relationship to patient: _____

If the patient answered "NO" to both questions 4 and 5, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

PART V – Disability

1. Are you currently employed?
   - _____ Yes Name and address of your employer: _____
   - _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   - _____ No *Never employed*

2. Do you have a spouse who is currently employed?
   - _____ Yes Name and address of employer: _____
   - _____ No *If applicable,* date of retirement: **MM/DD/YYYY**
   - _____ No *Never employed*

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?
   - _____ Yes, *both*
   - _____ Yes, *self*
   - _____ Yes, *spouse*
   - _____ No **Stop. Medicare is primary unless the patient answered yes to questions in Part I or II.**

4. Are you covered under the GHP of a family member other than your spouse?
   - _____ Yes Name and address of your family member's employer: _____
   - _____ No

5. Does the employer that sponsors your group health plan (GHP) employ 100 or more employees?
   - _____ Yes **Stop. GHP is primary. Obtain the following information.**
     - Name and address of GHP: _____
     - Policy identification number: _____
     - Group identification number: _____
     - Name of policy holder: _____
     - Relationship to patient: _____
   - _____ No **Stop. Medicare is primary unless the patient answered yes to questions in Part I or II.**

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
   - _____ Yes **GHP is primary. Obtain the following information.**
     - Name and address of GHP: _____
     - Policy identification number: _____
     - Group identification number: _____
     - Name of policy holder: _____
     - Relationship to patient: _____
   - _____ No

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
   - _____ Yes **GHP is primary. Obtain the following information.**
     - Name and address of GHP: _____
     - Policy identification number: _____
     - Group identification number: _____
     - Name of policy holder: _____
     - Relationship to patient: _____
   - _____ No

If the patient answered "NO" to questions 5, 6, and 7, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?
   _____ Yes Name and address of GHP: _____
   Policy identification number: _____
   Group identification number: _____
   Name of policy holder: _____
   Relationship to patient: _____
   Name and address of employer, if any, from which you receive GHP coverage:
   _____
   _____ No **Stop. Medicare is primary.**

2. Have you received a kidney transplant?
   _____ Yes Date of transplant: **MM/DD/YYYY**
   _____ No

3. Have you received maintenance dialysis treatments?
   _____ Yes Date dialysis began: **MM/DD/YYYY**
   If you participated in a self-dialysis training program, provide the date training started: **MM/DD/YYYY**
   _____ No

4. Are you within the 30-month coordination period?
   _____ Yes
   _____ No **Stop. Medicare is primary.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   _____ Yes
   _____ No

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   _____ Yes **Stop. GHP continues to pay primary during the 30-month coordination period.**
   _____ No **Initial entitlement based on age or disability.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

   _____ Yes **GHP continues to pay primary during the 30-month coordination period.**
   _____ No **Medicare continues to pay primary.**

FOR OFFICE USE ONLY: REVIEWED BY: _____ DATE: _____
COMMENTS:

Cheyenne Regional Medical Center

Patient Name_____Date of Birth_____
Height_____Ft_____inches Weight_____ Blood pressure _____Heart Rate_____

Chief Complaint:

Allergies: (Also, Type of Reaction)

Medications/Dose/Route/Frequency/Provider (Can attach current MAR):

Medical History: (circle answer)

ADD/ADHD	Yes	No	Psychosis	Yes	No	Anxiety	Yes	No
Liver Disease	Yes	No	PTSD	Yes	No	Bipolar disorder	Yes	No
Neuropathy	Yes	No	Borderline Personality	Yes	No	OCD	Yes	No
Seizures	Yes	No	Depression	Yes	No	ODD	Yes	No
Thyroid Disease	Yes	No	Fatigue	Yes	No			

Other Medical History:

Patient Name_____ Date of Birth_____

Medical History: (circle answer)

ADD/ADHD	Yes	No	Fatigue	Yes	No	Psychosis	Yes	No
Anxiety	Yes	No	Liver Disease	Yes	No	PTSD	Yes	No
Bipolar Disorder	Yes	No	Neuropathy	Yes	No	Schizoaffective Disorder	Yes	No
Borderline Personality	Yes	No	OCD	Yes	No	Seizures	Yes	No
Depression	Yes	No	ODD	Yes	No	Thyroid Disease	Yes	No

Other diagnosis:

_____

_____

_____

_____

_____

Surgical History:

Appendectomy	Yes	No	Cosmetic Surgery	Yes	No	Prostate Surgery	Yes	No
Brain Surgery	Yes	No	Eye Surgery	Yes	No	Small Intestine Surgery	Yes	No
Breast Surgery	Yes	No	Fracture Surgery	Yes	No	Spine Surgery	Yes	No
C-Section	Yes	No	Hernia Repair	Yes	No	Tubal Ligation	Yes	No
CABG	Yes	No	Hysterectomy	Yes	No	Valve Replacement	Yes	No
Cholecystectomy	Yes	No	Joint Replacement	Yes	No	Vasectomy	Yes	No
Colon Surgery	Yes	No						

Other Surgical History:

_____

_____

_____

_____

_____

Patient Name_____ Date of Birth_____

Females- Having Periods: _____ _____Yes _____No

If yes, what is the date of LMP: (If unknown, state unknown) _____ *Within:* ____*Days* _____*Weeks* _____*Months*

If no, what is the reason? (ex: hysterectomy, medications, injections, menopause (pre or post), recent pregnancy)

_____

Family Psychological History:

Relationship	Status Alive or Deceased	ADD/ADHD	Alcohol Abuse	Anxiety	Bipolar	Dementia	Depression	Drug Abuse	OCD	Paranoid Behavior	Physical Abuse	Schizophrenia	Seizures	Sexual Abuse
Mother														
Father														
Sister														
Brother														
Maternal Aunt														
Paternal Aunt														
Maternal Uncle														
Paternal Uncle														
Maternal Grand Father														
Maternal Grand Mother														
Paternal Grand Father														
Paternal Grand Mother														

☐ **Adopted** ☐ **Family History Unknown**

Patient Name_____ Date of Birth_____

Social History:

Alcohol Use: _____Yes _____No

If yes, How often? _____

Drinks per week:

_____Glasses of Wine _____ Cans of Beer _____ Shots of Liqueur _____Drinks containing 0.5oz Alcohol

Sexually Active: _____Yes _____No _____Not currently

Partners: _____Female _____Male

Birth Control: _____Yes _____No *If yes, what form?* _____

Drug Use: ___Yes _____No (past or present)

Circle all that apply:

Amphetamines	Amyl Nitrate	Anabolic Steroids	Barbiturates	Benzodiazepines	Cocaine/ "crack"
Codeine	Fentanyl	Flunitrazepam	GHB	Hashish	Heroin
Hydrocodone	Hydromorphone	Ketamine	LSD	Marijuana	MDMA (Estacy)
Mescaline	Methamphetamines	Methaqualone	Methylphenidate	Morphine	Nitrous Oxide
Opium	Oxycodone	PCP	Psilocybin	Solvent Inhalants	Other: _____

Tobacco Use:

_____Current every day _____Current some days
_____Former Smoker _____Never Smoked
_____Passive Smoke Exposure Never Smoker
Packs per day smoked: Quit Date: _____ Ready to Quit: _____Yes _____No

Exercise History:

Currently exercising: _____Yes _____No _____Unable to exercise
How often per week? _____ Type of Exercise: _____

Patient Name _____ Date of Birth _____

Outpatient Ambulatory Screening

If you are 18 years or older please answer the following questions (1-16).

1. Do you feel safe at home? Yes ____ No ____
2. Do you feel like anybody is taking advantage of you financially? Yes ____ No ____
3. Do you have cultural or religious needs? Yes ____ No ____
4. Any unplanned weight loss or gain in the last 3 months? Yes ____ No ____

   If yes, how many pounds? _____
5. Do you feel like you have enough resources to buy food? Yes ____ No ____
6. Have you fallen in the last 90 days? Yes ____ No ____

   If yes, explain briefly: (cause of fall, any injuries?) _____
7. Dressing: _____Independent _____Needs Assistance _____Dependent _____Unable to Assess
8. Grooming: _____Independent _____Needs Assistance _____Dependent _____Unable to Assess
9. Feeding: _____Independent _____Needs Assistance _____Dependent _____Unable to Assess
10. Mobility Assistance: _____Independent _____Independent w/Assistive device _____Needs Assistance

Patient Name _____Date of Birth_____

11. Do you have an advance directive? Yes ____ No _____

12. Do you have a psychiatric advance directive? Yes ____ No _____

13. Learning Preference (Please circle)

Reading Hands-on Demonstration Video Other_____

14. Do you have any barriers to learning? (Please circle)

None Hearing Speech Visual Difficulty reading/writing Unable to understand/follow directions

Level of consciousness Level of Motivation Developmental age/cognitive impairment

15. Primary English? _____English _____Spanish Other: _____

16. Do you need any additional information?

None Community Resources Current Illness Equipment Activity Diet Home care Medications

Other_____

Patient Name _____Date of Birth_____

1. Have you had any recent thoughts of taking your own life?

   _____

2. Do you have any thoughts of harming yourself or others?

Pain Screening

Are you currently in any pain? _____Yes _____No

If yes:

Location: _____

Chronic or Acute Pain: _____

Rate (0-10): _____

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PATIENT HEALTH QUESTIONNAIRE

STAMPER OR PATIENT LABEL

PATIENT HEALTH QUESTIONNAIRE PHQ-9

Patient Signature: _____ DOB: _____ Date: _____

Physician: _____ Admission / Discharge

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "√" to indicate your answers.)

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

(The staff will add the columns.) _____ + _____ + _____

Total: _____

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 people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Comments: _____

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PATIENT HEALTH QUESTIONNAIRE

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