FAMILY HEALTH & WELLNESS CENTER

1500 E Cedar Ave., Ste 26, Flagstaff, Arizona 86004

PATIENT INFORMATION SHEET

Name(Last, First, Middle):		Other Names Used(Alias):	Sex: M F	Chart #:
Date of Birth:	Place of Birth(City & State):	Social Security #:	Primary Language:	Secondary Language:
Mailing Address: City/State: Zip Code:			Primary Phone #:	
Current Community: Date Moved:			Secondary Phone #:	
Marital Status: __SINGLE SEPERATED __COMMON-LAW DIVORCED __MARRIED WIDOWED	Ethnicity: __NATIVE AMERICAN __CAUCASIAN __HISPANIC __OTHER:______________	Primary Tribal Enrollment:	Degree:	Census Number:
		Other Tribe(s):	Degree:	Religious Preference:
Employer Information: __EMPLOYED(FULL-TIME) DISABLED __EMPLOYED(PART-TIME) STUDENT __UNEMPLOYED CHILD UNDER 4 __RETIRED	Patient's Employer: Employer Address: Phone #:			
	Spouse's Employer: Employer Address: Phone #:			
Preferred Contact Method: __PHONE MAIL EMAIL NONE	Internet Access: __YES __NO	Where:	Email Address:	
Are you related to a NACA Employee? Please list Name & Dept. :				

PARENTAL INFORMATION for MINORS

Fathers Name:	Father's Employer:	Contact Phone #:	Place of Birth: (City/State)
Mother's Maiden Name:	Mother's Employer:	Contact Phone #:	Place of Birth: (City/State)

HEALTH INSURANCE INFORMATION

Medicare Number:	Suffix:(A,B & D):	Part A Eligibility Date:	Part B Eligibility Date:
AHCCCS ID #:		Plan Name:	Eligibility Date:
Private Insurance Company Name:		Policy ID#:	Insurance Phone #:
Policyholder's Name:	Policyholder's Date of Birth:	Group #:	Effective Date:

EMERGENCY CONTACT AND NEXT OF KIN INFORMATION

Name of Emergency Contact:	Phone # of Emergency Contact:	Relationship to Patient:
Emergency Contact's Address:	City/State:	Zip Code:
Name of Next-of-Kin Contact	Phone # of Next-of-Kin Contact:	Relationship to Patient:

MILITARY SERVICE INFORMATION

Military Service: __Yes No	Vietnam Veteran: __Yes No	Branch:	Entry Date:	Separation Date:	Service Connected: __Yes No

* I certify that the information on this form is true and accurate, as of the date of signature.
* I agree to contact NACA if the information on this form changes in any way.
* I hereby authorize NACA to furnish information to insurance carriers concerning my illness, and I hereby irrevocably assign to NACA payments for medical services rendered.
* I understand that I am financially responsible for ALL charges whether or not covered by insurance.

Patient Signature Date

GENERAL CONSENT FOR TREATMENT

Patient/Client Name: ________________________________ Date of Birth: _____________

General Consent for Treatment

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology, and laboratory procedures and medication prescription and administration.

I understand no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure, unless there is an emergency or extraordinary circumstance. Informed consent means the provider will disclose to me expected benefits and risks of a particular procedure and/or treatment. This understanding includes research and/or experimental procedures will not be performed without my knowledge and consent.

Release of Medical Information

I authorize *Native Americans for Community Action, Inc*. (NACA) to use my health information related to the services provided for the following purposes: my treatment, obtaining payment for the services provided, and for health care operations of NACA or other treating providers, as permitted under federal and state laws and regulations.

Payment

I assign and authorize payment for all services provided directly to NACA from my insurance company or third party payer, including, but not limited to, Medicare, AHCCCS, commercial health insurance, automobile no-fault insurance, and workers compensation insurance.

In consideration of the health care services provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, and non-covered services.

I have read this consent form, or it has been read to me, and I understand the contents. My questions have been answered to my satisfaction.

____ ____________________

Signature of Patient/Client Date

____ ____________________

Signature of Parent/Guardian (if applicable) Relationship to Patient/Client

____ ____________________

Signature of Witness Date

ACKNOWLEDGEMENT OF INFORMATION RECEIVED

Patient/Client Name: ___________________________________ Date of Birth: ______________

I confirm I have received the following information in writing, and understand its content. I understand it is my responsibility to address any further questions I have regarding this information with my medical practitioner, case manager, nurse, therapist, and/or counselor.

_______ I have read and understand the **Patient/Client Rights and Responsibilities**, including the grievance
Initial procedure and mandatory reporting requirements.

_______ I have read and understand the **HIPAA Notice of Privacy Practices**, including who to contact if I
Initial suspect my protected health information has been compromised.

_______ I have been offered information regarding **Advance Directives** and my options for establishing
Initial advance directives and/or a power of attorney.

_______ I have received a copy of the **Fee Schedule** and understand I am responsible for payment for services
Initial received. I agree to cancel appointments at least 24 hours in advance or agree to pay a $25 cancellation fee.

_______ I have read and understand NACA Family Health Center's participation in the Health Information
Initial Exchange and read the **Notice of Health Information Practices**.

____ ____________________
Patient/Client signature Date

____ ____________________
Parent/Guardian signature (if applicable) Date

____ ____________________
Employee/Witness signature Date

Annual Health Risk Assessment

Date ______________________ Date of birth ______________________

Name ______________________ Name Listed with Insurance (if different) __________________________

Pronouns ______________________

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Do you have a dentist you see regularly?	☐ Yes ☐ No
How many times in the last sixmonths have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
How many times in the last six months have you been admittedto the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
Rate your pain on a scale of 0-10, where 0 means no pain at all and 10 means the worst pain imaginable.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Allergies and Reactions	
Medication	Name(s): ☐ None Reaction(s):
Foods	Name(s): ☐ None Reaction(s):
Insects/Animals	Name(s): ☐ None Reaction(s):

Medications	
Do you take any over-the-counter medication (vitamins, supplements, herbal medicines)?	☐ Yes ☐ No
How many times in the last month have you missed taking your medications?	________ times ☐ I do not take medications
How many times in the last month have you taken your medications differently than prescribed by your doctor?	________ times ☐ I do not take medications
Do you have enough money to pay for the medications, medical supplies, and medical visits you need?	☐ Yes ☐ No

Nutrition	
How many servings of fruit and vegetables do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many servings of fiber or whole grain foods do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many servings of meat, fish, or other protein do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many times do you eat fast food during the week?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many times during the week do you reduce the size of your meals or skip meals because you don't have enough money, or enough help to shop or cook?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7

Physical Activity	
How many days a week do you exercise?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't exercise
On the days you exercised, how long did you exercise?	☐ 0-30 min ☐ 30 min – 1 hour ☐ More than 1 hour ☐ I don't exercise
What kind of exercise routine do you have?	☐ Light (walking, stretching) ☐ Heavy (jogging, swimming) ☐ Routine activities (cleaning, gardening, shopping) ☐ I don't exercise

Tobacco Use	
Do you use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes)?	☐ Yes ☐ No If yes, how any packs/time per day? ________________ How many years? __________________
Are you interested in quitting?	☐ Yes ☐ No
Have you had a lung cancer screening?	☐ Yes ☐ No

Alcohol Screening	
Have you ever felt you should cut down on your drinking?	☐ Yes ☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking?	☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	☐ Yes ☐ No

SCORE:

Fall Risk	
Have you had any problems with balance or walking in the last year?	☐ Yes ☐ No
Have you had more than one fall in the last year?	☐ Yes ☐ No
Have you had an injury from a fall in the last year?	☐ Yes ☐ No

Social Support	
What is your current living situation?	☐ House/apartment (stable) ☐ With friends/family (temporary) ☐ In a shelter ☐ In a hotel since: ☐ In a vehicle ☐ On the street
Who do you live with?	
Which of the following applied to you?	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other activities ☐ None
How often do you get out and meet with family and friends?	☐ Often ☐ Sometimes ☐ Almost Never ☐ None
Do you have transportation to medical appointments?	☐ Yes ☐ No
In the last 12 months, have you needed to see a doctor but could not because of cost?	☐ Yes ☐ No
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	☐ Yes ☐ No
Do you need help reading hospital or clinic material?	☐ Yes ☐ No
Do you or your caregiver have enough help with resources or caregiving duties? (Skip, if you do not give or receive care)	☐ Yes ☐ No
Is anybody mistreating you physically or financially?	☐ Yes ☐ No

If you answered yes, to any of these questions would you like to receive assistant with any of these needs?	☐ Yes ☐ No
Are any of your needs urgent? For example, I don't have food tonight or I don't have a place to sleep tonight.	☐ Yes ☐ No

Depression Screening *In the last two weeks, how often have you been bothered by any of the following problems?*	
Little interest or pleasure in doing things	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Depression Screening continued *In the last two weeks, how often have you been bothered by any of the following problems?*	
Trouble falling asleep or sleeping too much	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling tired or having little energy	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Poor appetite or overeating	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling bad about yourself or that you're a failure or have let yourself or your family down	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things such as reading the newspaper or watching television	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Moving or speaking so slowly that other people could have noticed or the opposite, being so fidgety or restless that you've been moving around a lot more than usual	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Thoughts you would be better off dead or of hurting yourself	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home or get along with others?	☐ Not at all ☐ Somewhat difficult ☐ Very difficult

SCORE:

Domestic/Intimate Partner Violence	
Do you feel safe with people you live or spend time with?	☐ Yes ☐ No
Are you afraid to go home?	☐ Yes ☐ No
Has anyone forced you to have sexual activities recently?	☐ Yes ☐ No
Interventions	
I would like to learn more	☐ Yes ☐ No
I am not interested at this time	☐ Yes ☐ No

Colorectal Cancer Screening *(all patients, age 45-75 years)*	
Have you had a fecal immunochemical (FIT) test in the last year? (FIT test: detects for human blood in your stool sample)	☐ Yes ☐ No
Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No ☐ Not sure

Breast Cancer Screening *(all women ages 50-74 years)*	
Have you had a mammogram within the last year?	☐ Yes ☐ No ☐ Not sure

Cervical Cancer Screening *(all women ages 21-65)*	
Have you had a pap smear within the last 3 years?	☐ Yes ☐ No ☐ Not sure

Advance Care Planning	
Have you discussed who in your family would make decisions about the care you would want to receive if you become unable to speak for yourself?	☐ Yes ☐ No
Do you have a health care power of attorney or a living will?	☐ Yes ☐ No
Would it be okay if we discussed this further with you today?	☐ Yes ☐ No

Your Medical History *(check if you have had any of the following conditions)*

☐ Alcoholism	☐ Diabetes HbA1C & Date ___________	☐ Mental Illness
☐ Anemia	☐ Glaucoma	☐ Chronic Pain ☐ Opioid Use
☐ Asthma	☐ Hearing Loss	☐ Osteoporosis
☐ Arthritis	☐ Heart Attack	☐ Physical Disability
☐ Bladder Problems	☐ Heart Disease ☐ Statin Therapy	☐ Seasonal Allergies
☐ Blindness	☐ Heart Failure	☐ Seizure Disorder
☐ Blood Clots	☐ Hepatitis	☐ Sleep Disorder
☐ Breast Cancer	☐ High Cholesterol ☐ Statin Therapy	☐ Stomach Disorder
☐ COPD	☐ Hypertension	☐ Stroke
☐ Colon Cancer/Polyps	☐ Irregular Heartbeat	☐ Thyroid Disease
☐ Cancer – Other	☐ Kidney Disease	☐ Tuberculosis
☐ Depression	☐ Liver Disease	☐ Ulcer

Your Family's Medical History *(check if a relative has or have had one of these conditions)*

☐ Alcoholism	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Alzheimer's	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Dementia	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Breast Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Colon Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Cancer (Other)	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Diabetes	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Mental Illness	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Hypertension	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Heart Attack	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Osteoporosis	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Seizures	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Stroke	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling

Sexual Health History

What is your gender? What is your assigned gender at birth if different?	
What is your sexuality?	☐ Heterosexual (straight) ☐ Gay/lesbian ☐ Bisexual ☐ Other (please list):
What is your current relationship status?	☐ Single ☐ Married ☐ Divorced/separated ☐ Widowed ☐ Partnered ☐ Other (please list):
What is the gender of your partner(s)?	
How do you practice "safer sex" (condoms, monogamy, STD testing, etc.)?	
Have you ever been diagnosed or treated for a sexually transmitted infection?	☐ Yes ☐ No Name/date/treatment:
Have you ever had a menstrual period? Age at 1st period? Date last menstrual period began?	☐ Yes ☐ No (skip this section) Age: Date:
Are you capable or have you ever been capable of becoming pregnant? Have you ever been pregnant? Do you use any kind of birth control? Have you or are you currently going through menopause?	☐ Yes ☐ No (skip this section) ☐ Yes ☐ No If yes, how many times: How many births: Type: ☐ Yes ☐ No ☐ Unsure If yes, what age:

Past Surgeries

List of Medicines and Supplement, you take	
Name if medicine/supplement	Dose and frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Other Health Care Providers	
Provider Name	Specialty

Medical Equipment and Suppliers	
Type of Medical Equipment (examples: oxygen tank, etc.)	Name of Supplier