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: Where: __YES __NO	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.

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

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

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

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

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

_____ _____

Patient/Client signature Date

_____ _____

Parent/Guardian signature (if applicable) Date

_____ _____

Employee/Witness signature Date

Chart # _____ Date _____

NACA Family Health Center

Patient Health Questionnaire (PHQ-9) **Modified for Teens**

In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your provider. Thank you for taking an active part in your health care.

If the health screenings are positive, would you like to be contacted by the Behavioral Health Department? ☐ Yes ☐ No

Over the last two (2) weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself– or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work reading, or watching TV?	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 are 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

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY Score _____

Score/Chart Action: 0-14 Chart only, ≥15: BH Referral and Chart

Tobacco Screening

Tobacco Use: Current Use? ☐ Yes ☐ No Ever? ☐ Yes ☐ No # Packs _____ Years _____

Do you want to quit? ☐ Yes ☐ No Would you like assistance to quit? ☐ Yes ☐ No

PLEASE RETURN COMPLETED FORM TO YOUR PROVIDER

Provider Initials and Date: _____

Chart # _____ Date _____

Cage Questionnaire: Screening test for Alcohol Dependence

Please check one response to each item that best describes how you have felt and behaved over your whole life.

Do you currently drink alcohol, beer or wine? ☐ Yes ☐ No *If no, please proceed to Intimate Partner/Domestic Violence Screening.

1. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No
3. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang-over (eye-opener)? ☐ Yes ☐ No

Healthcare Provider use ONLY:

Check One	Results:	Health Factor	Chart:
	Answers No to al four questions	Cage 0/4	
	Answers Yes to one of the four questions	Cage 1/4	Need for further clinical investigation including questions on amount, frequency, etc.
	Answers Yes to two of the four questions	Cage 2/4	Need for further clinical investigation and/or referral as indicated by clinician's expertise.
	Answers Yes to three of the four questions	Cage 3/4	Evaluate, treat and/or referral as indicated by clinician's expertise
	Answers Yes to al four questions	Cage 4/4	Evaluate, treat and/or referral as indicated by clinician's expertise

Intimate Partner/Domestic Violence Screening:

1. Are you in a relationship with a person who physically hurts or threatens you? ☐ Yes ☐ No
2. Have you ever been in a relationship with a person who hurt you? ☐ Yes ☐ No
3. Would you like to talk to someone about Intimate Partner/Domestic Violence? ☐ Yes ☐ No

Healthcare Provider use ONLY:

Check One	Results:	Health Factor:
	Negative	Denies being a current or past victim of IPV/DV
	Past	Denies being a current victim, but discloses being a past victim of IPV/DV
	Present	Discloses current IPV/DV (document health and safety assessment)
	Present & Past	Discloses past and current IPV/DV (document health and safety assessment)
	Unable to Screen	Chart
	Refused	Patient Declined exam or screening

PLEASE RETURN COMPLETED FORM TO YOUR PROVIDER

Provider Initials and Date: _____

Pediatric Health History

All information is kept strictly confidential

Child's Name	Birth date/ Age	M	F	Today's Date

1. Do you have any questions or concerns about your child? _____

_____

_____

2. Have there been any recent major changes or stresses in the child's life? ____YES ____NO

If YES, explain _____

_____

3. Does child go to a baby sitter, preschool or day care regularly? ____ YES ____NO

4. School and grade your child attends _____

BIRTH HISTORY

1. Was your child born: _____on time _____early _____late?

2. Birth weight_____ Length_____ Place_____

3. During the pregnancy did the mother see a doctor regularly? _____YES _____NO

4. During the pregnancy did the mother: (check all that apply)

_____ Have any medical problems? _____ Use any medications?

_____ Smoke or drink? _____ Use alcohol or other drugs?

_____ Have problems with labor/ delivery?

If YES, please explain _____

_____

5. How long did the baby stay in the hospital after birth? _____

PAST MEDICAL HISTORY

1. Is the child's general health: (check one) _____ Good _____ Fair _____ Poor

2. Is the child taking any medications? ____YES ____NO Name of medication _____

3. Fluoride? _____YES _____NO

4. Has your child seen a dentist? _____YES _____NO Date of last dental exam _____

5. Please list any hospitalizations, operations, serious illnesses or accidents with dates

_____Date_____

_____Date_____

_____Date_____

6. Does your child currently have, or has had in the past any of the following:

____ Allergies (medicine, other)
____ Anemia
____ Broken bone, joint injury or disorder
____ Asthma
____ Attention Deficit Disorder (ADHD)
____ Chronic headaches
____ Convulsions, seizures, epilepsy
____ Diabetes
____ Eye conditions (lazy eye, cross eyed, other)
____ Head Injury
____ Heart murmur or condition, high blood pressure
____ Long hospital stay
____ Colic, intestinal or digestive problems
____ Failure to thrive
____ Feeding/ Weight problems
____ Surgery
____ Dental problems (decay, baby bottle mouth)
____ Meningitis
____ Urinary infections
____ Tubes in ears
____ Chronic ear infections (3 or more a year)
____ Vision loss/ glasses
____ Exposure to drugs/alcohol during mother's pregnancy
____ Hearing loss/ aids
____ Learning delays (sat after 8 months, walked after 18 months, talked after age 2, other)
____ Special equipment: braces, walker, crutches, wheelchair, prosthesis, other _____
____ Therapy services: physical, occupational, speech, early intervention
____ Services from DDD, CRS, AZEIP, ASDB, other _____

Please describe any YES to the above questions: _____

_____

FAMILY HISTORY

1. Have any of the child's brothers or sisters died? ____ YES ____NO

(If YES, give age and cause) _____

2. Have any of the child's blood relatives had the following diseases?

____ Heart Disease
____ High Blood Pressure
____ Tuberculosis
____ Kidney Disease
____ Allergies/Asthma
____ Cancer
____ Diabetes
____ Seizures
____ Sickle Cell
____ Mental/Emotional Problems

Please describe any YES to above questions: _____

_____

DEVELOPMENT

1. Do you have any concerns about the following?

____ Development
____ Behavior
____ Eating habits
____ Sleeping habits
____ School experience
____ Discipline
____ Bathroom/toilet habits
____ Other (explain)_____

If YES, please explain _____