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 Telehealth 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 may result in delay of care.
Patient Registration Form

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 Separated □ 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
Patient Registration Form

INSURANCE INFORMATION

Primary 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
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 permission 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 ____________________________________________________________

WHITE - MEDICAL RECORDS YELLOW - PATIENT

(CNT) (REV. 09/05ff ups eliminated 06/07 sdg 12/2010br, Epic 3/2013)
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.
Authorization to Release
Health Care Information and/or
Behavioral Health Care Information

(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
☐ MD Notes  ☐ Echo(s)  ☐ Progress Notes
☐ ER/Urgent Care Record  ☐ EKG/Tracings  ☐ Immunizations
☐ History & Physical(*)  ☐ LAB(s)  ☐ Medications
☐ Consult(s)(*)  ☐ Pathology Reports  ☐ HIV test results
☐ Operative/Proc Note(*)  ☐ Radiology Reports(*)  ☐ Treatment Plans
☐ Discharge Summary(*)  ☐ EEG Reports  ☐ Nursing Records
☐ Psych Eval  ☐ Sleep Studies  ☐ Other (please specify)
☐ BH Eval/Assessments

(5) Purpose for Disclosure
☐ Personal  ☐ Continuity of Care  ☐ Worker’s Comp  ☐ Insurance  ☐ Disability  ☐ Legal
Other

(6) Delivery Method
☐ FAX  ☐ MAIL  ☐ PICK UP BY Patient or Designee
*There may be a charge/fee for copies of records.
Information needed by:

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(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Date  (Expires one year from signature date)

Relationship to Patient (if not patient)

Expiration Date

MRC Approved: 1/2014
Form# 21908
Cheyenne Regional
Page 1 of 1
Authorization to Disclose Health Information to Family or Other

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 _________ through _________.

Start __________________ 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 payer 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, date 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:
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)

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Other Medical History:
Medical History: (circle answer)

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Other diagnosis:

Surgical History:

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<td>No</td>
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<tr>
<td>Colon Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Cosmetic Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Eye Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Fracture Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Hernia Repair</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Hysterectomy</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Joint Replacement</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Prostate Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Small Intestine Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Spine Surgery</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Tubal Ligation</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Valve Replacement</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Vasectomy</td>
<td>Yes</td>
<td>No</td>
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</table>

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:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Status Alive or Deceased</th>
<th>ADD/ADHD</th>
<th>Alcohol Abuse</th>
<th>Anxiety</th>
<th>Bipolar</th>
<th>Dementia</th>
<th>Depression</th>
<th>Drug Abuse</th>
<th>OCD</th>
<th>Paranoid Behavior</th>
<th>Physical Abuse</th>
<th>Schizophrenia</th>
<th>Seizures</th>
<th>Sexual Abuse</th>
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<tbody>
<tr>
<td>Mother</td>
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<td>Maternal Grand Father</td>
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<td>Paternal Grand Mother</td>
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<td>Paternal Grand Father</td>
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<td>Paternal Grand Father</td>
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</tbody>
</table>

[] Adopted          [ ] Family History Unknown
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  Methamphetamine  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: ____________________________
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
10. Mobility Assistance: Independent Independent w/Assistive device Needs Assistance
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 __________________________
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): ____________________________________
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 "v" to indicate your answers.)

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

(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: ________________________________

MRC Approved: 9/2013

PAQ  (REV. 1/12, Epic 6/2013)  Behavioral Health Services - OP  Page 1 of 1