Texas Advance Behavioral Health

New Patient Forms

715 N. Fielder Rd. Arlington Tx 76012 * 1220 West Presidio St Fort Worth, Tx 76102
Office: 682-220-9615 **Email:** patientcare@txbehavioralhealth.com **Fax:** (817) 200-6813

Welcome to Texas Advance Behavioral Health (TABH)!

Our Mission at Texas Advance Behavioral Health is to provide quality compressive behavioral mental health services that promote health, stability, and quality of life.

Our vision is to be leaders of excellent personalized care, quality services, and accessible.

Our goals are to provide easy access to behavioral services and after hour care. Collaboration with your health care providers to increase quality of life and healthy living. Provide friendly, compassionate, and efficient care.

Texas Advance Behavioral Health is a place of hope, centered on health care that is personal and compassionate. Our clinical team is caring, compassionate, and well trained in biological and psycho-social aspects that contribute to behavioral, mental, and psychotic disorders.

In order for us to provider effective care please complete the attached evaluation forms. We looking for to helping you achieve a healthier and stable mental health.

Thank you for the opportunity to serve you!

TEXAS ADVANCE BEHAVIORAL HEALTH

NEW PATIENT FORMS

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Date /Fecha _____ Contact Number/ Numero _____

Name/Nombre (Last, First) _____ DOB _____ Sex * M * F

Address/DIRECCIÓN _____ City/CIUDAD _____ Zip _____

Email/ CORREO ELECTRÓNICO _____ Age _____
Patient Status student single married divorce
Paciente Estado Estudiante Individual Casado Divorcio
Race Asian/Vietnamese Black White Other **Carrera** □ Asiatica/Vietnamita Negro Blanco
ETHNICITY □ HISPANIC □ NOT HISPANIC □ DECLINE ETNICIDAD □ HISPANO □ NO HISPANO **Preferred Language** □ English □ Spanish □ Other _____ IDIOMA PREFERIDO □ Ingles □ Espanol

Primary Parent: _____ **DOB** _____/_____/_____

Local Pharmacy/ DE farmacia local _____ Phone/ Teléfono _____

Address/ City/Zip: Dirección/ciudad/postal _____

* If Patient is a minor on your insurance /Si el paciente es menor de edad:

Insured Name: _____ DOB _____/____/_____ Social# _____
Policy holder address same as above Address differ from patient

Address _____ city, state, zip _____

*** Please provide your Ins. Card to Office Staff To Finish The Rest ***

Primary Insurance * Aetna Cigna BlueCross PHCS (MultiPlan) Tricare Humana UHC Medicare
Medicaid * AetnaBH/Chip Beacon/Cooks Superior/Cenpatico CignaHS Molina/MkPl SSI Med
Patient ID # _____ Grp# _____

~ Claims Address Info ~ Effect Date _____ Ded _____ / _____ m2d OON _____$ OOP _____

Coverage _____ Co-Ins _____ Copay _____ Ins Phone _____

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Copy Ins Card

CONSENT FOR SERVICES AND TREATMENT

_____ _____

Patient Last name, First Name **Date of Birth**

I _____(*patient/ guardian name*) hereby give my authorization and consent for the above name to receive treatment for outpatient mental and behavioral service at Texas Advance Behavioral Health, LLC. by a *Board Certified Family Psychiatric Mental Health Practitioner.* Treatment consists of psychiatric examinations, diagnosis, and medication management. I understand that complete and accurate information is needed to help provide the best treatment plan and care. Which during my care as a patient are advisable, I understand that the purpose of these procedures will be explained to me and that while the course of medication management is designed to be helpful at time undesirable side effects may occur and it is my responsibility to communicate these occurrences to my provider. I understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment. I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law.

_____ _____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

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FINANCIAL AGREEMENT AND INSURANCE BENEFITS

I hereby assign all medical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to Texas Advance Behavioral Health, LLC. This assignment will remain in effect until revoked by myself in writing. A photocopy of charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify Texas Advance Behavioral Health of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and Texas Advance Behavioral Health clinic.

_____ _____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

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HIPPA PRIVACY NOTICE

I_____UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT TEXAS ADVANCE BEHAVIORAL HEALTH, OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY TEXAS ADVANCE BEHAVIORAL HEALTH TO:

A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY

B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS

C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY THROUGH TEXAS ADVANCE BEHAVIORAL CLINIC OR NETWORKING ORGANIZATIONS, AND

E) CONSENT TO PROPERTY TRANSFER OF SPECIMEN (TISSUE OBTAINED DURING MEDICAL TESTING) TO TEXAS ADVANCE BEHAVIORAL HEALTH.

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION.

I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MY OFFICE OR BY CONTACTING THEM AT 2261 BROOKHOLLOW PLAZA DR, STE 301, ARLINGTON, TX 76006 AND 1220 WEST PRESIDIO ST FORT WORTH, TX 76102.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) (DATE OF BIRTH IN MM/DD/YYYY)

_____ _____/_____/_____

(SIGNATURE OF PATIENT/GUARDIAN) (DATE OF SIGNATURE IN MM/DD/YYYY)

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FINANCIAL POLICY PATIENT CONSENT FORM

TEXAS ADVANCE BEHAVIORAL HEALTH, LLC. RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDER REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

I. PAYMENT: PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, TEXAS ADVANCE BEHAVIORAL HEALTH will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

II. SELF PAYMENT (PRIVATE, CASH PAYMENT):

If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional services.

III. MANAGED CARE: ALL MANAGED CARE (MH, PPM, etc.) CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.

IV. MEDICARE: TEXAS ADVANCE BEHAVIORAL HEALTH is a participating provider with the Medicare Program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

V. CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of TEXAS ADVANCE BEHAVIORAL HEALTH, LLC.

VI. SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. You agree to provide such information as outlined below. You agree to notify provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.

Initial/Complete as applicable:

_____I have NO SECONDARY INSURANCE COVERAGE

_____ I have SECONDARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM

Texas Advance Behavioral Health firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (682-220-9615).

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) **(DATE OF BIRTH)**

_____ _____/_____/_____

(SIGNATURE OF INSURED/GUARDIAN) **(DATE OF SIGNATURE)**

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Authorization for Use & Disclosure Release of Protected Health Information

I hereby authorize the □ release of □ obtaining of the medical records for: *Por la presente autorizo la* □ *liberación de* □ *la obtención de los registros médicos para:* □ **I do not at this time give my consent for my health records to be release or obtain** */En este momento no doy mi consentimiento para que mis registros de salud sean liberados u obtenidos.*

Patient's/*Paciente:* _____ Date of Birth/*Fecha de nacimiento* _____

Social Security:(adult only)*/Seguro Social: (sólo para adultos)* _____

Doctor/Facility: _____ Doctor/Facility: _____

Address: _____ Address: _____

City: _____ State/ Zip code _____ City: _____ State/ Zip code _____

Phone _____ Fax _____ Phone _____ Fax _____

Maria Mosomi, PMHNP-BC -Texas Advance Behavioral Health
2261 Brookhollow Plaza Dr, Ste 301 * Arlington, Texas 76006
1220 WEST PRESIDIO ST * FORT WORTH, TX 76102
Phone 817.962.0409 * Fax 817.394.7779

The specific purpose(s) for the disclosure of records is (check your selection): □ sharing with healthcare providers as needed □ sharing with psychologist □ other (describe) _____. This request/ authorization applies to Healthcare information relating to treatment and conditions. The Information to Be Released includes:

** *El propósito específico para la divulgación de los expedientes es (verifique su selección):* □ *compartir con los proveedores de atención médica según sea necesario* □ *compartir con el psicólogo* □ *otro (describir)* _____. *Esta solicitud / autorización se aplica a la información de salud relacionada con el tratamiento y las condiciones. La información que debe publicarse incluye:* (Please check specific information needed) *(Por favor, compruebe la información específica necesaria)*

□ Progress Notes/ *Notas de progreso* □ Medication Records/ *Registros de medicamentos* □ Treatment Plan/*Plan de tratamiento* □ Lab Data /*Datos de laboratorio* □ Verbal Communication /*Comunicación verbal*
□ Other/*Otros:* _____

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA); and all federal regulations and interpretive guidelines there under. **I**f the requestor or receiver is not a health care or plan provider, the released information may no longer be protected by Federal Privacy Regulation. **I** understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. **I** understand that the specified information to be released may include, but is not limited to: history, diagnoses, and or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS. **I** agree that a facsimile or photocopy of this authorization is as valid as the original. **I** understand this authorization is voluntary, that I my revoke this authorization in writing at any time except to the extent that actions has been taken in reliance upon the authorization. ***Esta Divulgación de Información demuestra el cumplimiento con la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA); Y todas las regulaciones federales y las pautas de interpretación allí debajo. Si el solicitante o el receptor no es un proveedor de atención médica o plan, la información liberada puede no estar protegida por el Reglamento Federal de Privacidad. Entiendo que mis registros son confidenciales y no pueden revelarse sin mi autorización por escrito, excepto cuando la ley lo permita. Entiendo que la información especificada para ser liberada puede incluir, pero no está limitada a: historia, diagnósticos y / o tratamiento de abuso de drogas o alcohol, enfermedades mentales o enfermedades contagiosas, incluyendo el VIH y el SIDA. Estoy de acuerdo en que un facsímil o fotocopia de esta autorización es tan válido como el original. Entiendo que esta autorización es voluntaria, que yo revocaré esta autorización por escrito en cualquier momento excepto en la medida en que se hayan tomado medidas en base a la autorización.*

Patient: _____ Parent/Guardian Sign (if minor) _____ Date Signed: _____

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Office Policies

Our Disclaimer By Law we collect Copay, co-insurance or deductible before we can provide service. It is considered INSURANCE FRAUD if we don't collect and bill your insurance. ~ Thank You

PLEASE INITIAL, SIGN and DATE THIS agreement

_____ PATIENTS ARE RESPONSIBLE FOR THEIR COPAYS, CO-INSURANCE OR DEDUCTIBLES FEES AT THE TIME SERVICE IS RENDERED BEFORE SEEING THE DOCTOR.

_____ THERE WILL BE A CHARGE OF $25 DOLLARS OR THE EQUIVALENT OF YOUR COPAY NO MORE THAN $50 DOLLARS FOR EACH **NO CALL NO SHOW** APPOINTMENT THAT YOU DO NOT GIVE 12 HOUR ADVANCE NOTICE TO CANCEL. (ALL MEDICAID CLIENTS ARE REQUIRED TO PAY $25 FOR NO SHOW FEES) (SITUATION PERMEABLE)

_____ THERE WILL BE A CHARGE OF $25 DOLLARS FOR **LAST MINUTE CANCELLATIONS GIVEN 4HRS OR LESS,** IF I DO NOT GIVE ADVANCE NOTICE (4 HOURS AT LEAST) TO RESCHEDULE THE APPOINTMENT (SITUATION PERMEABLE).

_____ IF YOU HAVE THREE OR MORE **NC/NS** OR MISSED APPOINTMENTS WITHIN ONE YEAR YOU WILL BE (IF NEEDED AT OUR DISCRETION) DISMISSED FROM THE PRACTICE.

_____ THERE WILL BE A $10 FEE TO REPLACE EXPIRED PRESCRIPTION, AND WE CANNOT BILL YOUR INSURANCE COMPANY.

_____ OUR POLICY IS TO REQUEST A POLICE REPORT TO REPLACE LOST OR STOLEN PRESCRIPTION.

_____ ALL OUTSTANDING PAYMENTS (AMOUNT DUE, NS/LMC FEES OR FINANCIAL RESPONSIBILITY) MUST BE PAID. PAYMENT ARRANGEMENTS CAN BE MADE BEFORE SEEING DOCTOR.

_____ I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL APPOINTMENTS NOT KEPT. (YOU'RE INSURANCE DOES NOT COVER LAST MINUTE, NO SHOWS, OR PAPERWORK FEES YOU MAY INQUIRE)

_____ I UNDERSTAND THAT BY CANCELLING AND/OR RESCHEDULING MY APPOINTMENT I AM RESPONSIBLE FOR MAKING SURE I (PARENT/PATIENT) HAVE ENOUGH MEDICATION UNTIL THE DOCTOR CAN SEE ME.

_____ I UNDERSTAND THAT IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN INSURANCE, IF I FAIL TO NOTIFY THIS OFFICE I WILL BE RESPONSIBLE AND CHARGED FOR ANY OUTSTAND VISITS MY INSURANCE DOES NOT COVER

_____ CELLULAR DEVICES, CAMERAS, CAMCORDERS OR ANY RECORDING /PHOTO DEVICES OR PROHIBITED. (TO REDUCE THE POTENTIAL RISK OF FEDERAL HIPPA VIOLATION RECORDING/PHOTO TAKING DEVICES ARE PROHIBITED)

_____ There are no exceptions to the above office policies! I understand the office policy may be amended or modified from time to time by the practice.

If you have any question ask the office staff for assistance. We will be glad to reschedule your appointment if necessary.

_____ _____

Signature (Patient/Guardian) Today's Date

Please read/sign

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Grievance Procedure

We are committed to you and you mental health needs here at Texas Advance Behavioral Health. It you have concerns, feedback, or complaints we would like to know. The process for patient who have a complaint or a questions is to :

1. Begin by discussing the concern with our front **Patient care staff.** This will often clear up any misunderstanding.
2. If your concern is not dealt with to your satisfaction, you may inform our **Clinical Manager** at **682-220-9615** or at patientcare@txbehavioralhealth.com
3. If your concern is not dealt with to your satisfaction, you may **speak to your provider or email your provider** so they may assist you.

Disclosure of Fee

Most fees or for office and/or hospital procedures. However, fees will also be incurred when you request services in addition to your regular services. Brief, non-comprehensive listing of such services:
-Medical records copied/transferred $25 and up
-Letter to employers, schools, court etc $25 and up (not including school/work note)
-Medical FMLA paperwork 75$ and up (depending on amount)
-We Do not accept Check
-We Do not Fill out Disability /Workmen Comp forms or letter
-Missed or NS scheduled appointments with less than 12hr notification a fee of $50
-Canceling scheduled appointment with less than 12hr notification a fee of $25
-Our office under no circumstance will fill out forms or letters for CHL (Concealed handgun permit) or Handicap Stickers.
-We are not contracted by any government, commercial or medical entity therefore we may refuse to sign and forms or letter you may bring in, that is our right.

The above fee or not covered thru your insurance plan, and are payable at time of service rendered.

Patient/Guardian Name_____ Date: _____

Evaluations for Litigation Purposes

Dear Clients,

Please be advised that Texas Advance Behavioral Health does not provide evaluations (diagnoses) or treatments for litigation purposes. Litigation purposes would include criminal cases, divorce, personal injury and emotional distress types of cases, among others. If you are looking to get an evaluation for a litigation purpose and or disability we recommend that you get a physician and/or psychologist who is specialized in performing such legal evaluations and treatment.

The providers at Texas Advance Behavioral Health do not provide litigation evaluations our purpose is strictly to assist you.

I acknowledged that I have read and understand the above statement.

_____ _____

(Patient signature) (Date)

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CONTROLLED SUBSTANCE POLICY

(This policy only applies to ADD, ADHD and Anxiety Meds)

____ Controlled Stimulants prescriptions **expire 21 days** after the appointment date, please make an effort to fill them in the appropriate time frame.

____ If you feel your child's medication needs to be increased, please discuss this during your office visit, not over the phone as the practitioner will not increase meds via phone calls.

____ If your medication is lost/stolen, we will not rewrite any prescription without **a police report**. We encourage you to turn in or fill all prescriptions when they are issued.

____ If you or your child is using illicit drugs of any kind we will no longer prescribe your medication.

____ If you alter the original prescription in any way we will no longer prescribe your medication.

____ If we discover you are getting the same prescription drugs from multiple pharmacies and/or physicians, we will no longer prescribe your medication.

____ We do not do medication refills (especially controlled substances). You are required to make and keep your appointments as recommended in order to obtain these medications. If you know you will have to miss an appointment due to illness or another obligation, it is **your responsibility** to call and reschedule in order to avoid a disruption in your medication.

____ We reserve the right to stop prescribing your medication if we feel there is a legitimate reason to include but not limited to: suspicious behavior, reports of misuse of medication, reports of illegal drug use/alcohol via urine/toxic screen.

____ We reserve the right to terminate our service with you, if we feel there is a legitimate reason to include: Verbal abuse to our providers/staff, Threatening of any kind to the providers/staff, etc.

The guidelines in this policy are non-negotiable, please do not ask the providers to deviate from this policy.

Patient name _____ Guardian Signature _____ Date _____

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INITIAL INTAKE QUESTIONNAIRE

PATIENT'S NAME:_____ **Date of Birth:**_____ **Todays Date:**_____

Who referred you to the clinic?_____

What brings you to the clinic? (CHIEF COMPLAINT):_____

PSYCHIATRIC HISTORY: Do you have any Psychiatric problems/ History:

[ ] No past psychiatric history [ ] Eating d/o [ ] depression [ ] anxiety [ ] ADHD [ ] bipolar[ ] schizophrenia[ ]Excessive Crying

[ ] Excessive Sleeping during the Day [ ] High irritability [ ] Mood Swings [ ] Nightmares [ ] Hallucinations [ ] Sleep Disturbance

[ ] Feeling Nervous [ ] Weight Gain [ ] Weight Loss

PSYCHIATRIC MEDICATION:Are you taking any psychiatric medications? [ ] None [ ] Yes. Please list all medications:

_____

_____

Have you been hospitalized? [ ] None. [ ] Yes: Where have you been hospitalized and when?

_____

Have you ever attempted suicidal: [ ] No attempts. [ ] Yes: When:

_____

Do you have any legal issues? [ ] None. [ ] Yes. Please list issue(s):_____

PATIENT'S MEDICAL HISTORY: [ ] No medical history

[ ] High blood pressure (HTN) [ ] Diabetes (DM) [ ] Seizure (SZ) [ ] Sexually Transmitted Diseases (STD's)
[ ] head trauma [ ] high cholesterol (dyslipidemia) [ ] anemia [ ] hypo or hyperthyroidism [ ] liver problems
[ ]kidney problem [ ] cardiac problems [ ] surgeries:_____
LMP:_____

FAMILY PSYCHIATRIC HISTORY: **[ ]** No any past family psychiatric history
[ ] Eating d/o [ ] depression [ ] anxiety [ ] ADHD [ ] bipolar[ ] schizophrenia Who in the family has psychiatric disorders:_____

FAMILY MEDICAL HISTORY: [ ] No family medical history

[ ] High blood pressure (HTN) [ ] Diabetes (DM) [ ] Seizure (SZ) [ ] Sexually Transmitted Diseases (STD's)
[ ] head trauma [[high cholesterol (dyslipidemia) [ ] anemia [ ] hypo or hyperthyroidism [ ] liver problems
[ ]kidney problem [ ] cardiac problems [ ] surgeries:_____
Other porblems:_____

PREVENTIVE CARE: Who is your Primary Care Provider: [ ] None.
Name:_____Last seen:_____

SOCIAL HISTORY:

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Who does the patient currently lives with:___ _____

Have you had any CPS cases: [ ]None [ ] Yes. When:_____

Employment: [ ] None [ ] Where do you work:

_____

Education: Highest School Grade:_____Name of school_____

Learning Disabilities: [ ] None [ ] Yes reports: _____

Special education placement: [ ] None [ ] Yes reports: _____

ABUSE HISTORY: Have you been abused physically, emotionally, or sexually? [ ] No. [ ] Yes reports:

_____

SUBSTANCE ABUSE: Do you use any drugs or alcohol? Do you smoke ? [ ] No.

[ ] Yes reports: What you use and when you used last._____

DEVELOPMENTAL HISTORY (Child & Adolescents Only): Was the patient born premature? When did they walk and talk? Patients Birth Weight?

_____

REVIEW OF SYSTEMS -Circle if you have had any of this symptoms in the last month:

Constitutional: (-)fever, (-)night sweats, (-)fatigue, (-)daytime ,somnolence, (-)polydipsia, (-)polyphagia, *See Vitals*

Eyes and Ears: (-)change in vision, (-)loss of vision, (-)blurred vision, (-)diplopia, Denies any hearing problems.

Respiratory: (-)dyspnea, (-)cough, (-)cough productive of sputum

Cardiovascular: (-)chest pain, (-)palpitations, (-)dyspnea at rest, (-)dyspnea with activity, (-)orthopnea

Gastrointestinal: (-)abdominal pain, (-)nausea, (-)vomiting, (-)constipation, (-)diarrhea

Urinary: (-)dysuria, (-)increased urinary frequency, (-)urinary incontinence

Dermatologic/Integumentary: (-)dry skin, (-)rash, (-)bruising

Musculoskeletal: (-)muscle pain, (-)muscle cramps, (-)muscle weakness, (-)decreased muscle strength, (-)difficulty walking

Neurological: (-)HA, (-)vertigo, (-)lightheadedness, (-)tremor, (-)difficulty speaking, (-)memory loss, (-)difficulty concentrating