

Saint Luke's Psychiatry

Your upcoming appointment will be with _____.

Saint Luke's Psychiatry & Neuropsychology Building

4225 Baltimore Avenue, Kansas City, MO 64111

(Located across the street from the Vietnam Veterans Memorial Fountain. Parking is available behind our building. Handicapped parking is available in the lot north of our building.)

<p><u>Appointment Date/Time:</u></p> <p>_____</p> <p>_____</p>	<p><u>Arrival Time:</u></p> <p>_____</p> <p><i>Late arrivals may result in the rescheduling of your appointment.</i></p>
<p><u>Copayment Amount:</u></p> <p>\$ _____</p>	

Initial Visit Checklist:

- Bring the attached paperwork **FULLY COMPLETED** with you to your appointment.
- Bring a **current list** of your medications and allergies.
- If there are memory or cognition concerns we request you bring a family member or caregiver with you.
- Please make sure you bring any assistive devices, medical equipment, or medicine you may need such as eyeglasses, hearing aids, a glucometer, wheelchair, walker, etc.
- Bring the copayment amount listed above.

If for any reason you are unable to keep this appointment or have any questions regarding this appointment please contact our office at **816-932-1711** to reschedule.

Thank you for your cooperation.

Saint Luke's Psychiatry Office Policy

Office Hours and Appointments

- This office is open Monday through Friday from 8:30am to 4:30pm. To schedule a visit please call during business hours at **816-932-1711**. Please update our office staff of any changes of address, phone number or insurance coverage prior to your visit or upon arrival.
- If you are unable to keep your appointment, please call at least 24 hours in advance. After three missed appointments (without 24 hours notice), you may be discharged from care.
- If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

Co-payment Collections

- All co-payments and payments towards any deductibles will be collected at the time of service. If you are unable to provide required payment at the time of service you may be rescheduled until this is resolved. If you do not provide current and accurate insurance information for each visit you may be financially responsible for those services provided.
- There may be additional fees for completing forms, such as disability or FMLA requests.

Prescription Refills

- Please review your prescription bottles prior to your appointment so that medications can be refilled when you see your provider.
- In between visits, please contact your pharmacy first for refills on your medication. Refill requests will normally be processed within two business days. Please plan accordingly and request refills at least five days prior to when your prescription ends.
- Medications which are controlled substances, including medications used for anxiety, insomnia and ADHD, may take additional time to process. In most cases, controlled medications require an office visit with your provider to obtain refills.

Thank you in advance for your cooperation with our office policy. Your compliance will improve our ability to serve you and others. Please call our office staff with any questions.

4225 Baltimore Ave, MO 64111 ♦ 816-932-1711

Saint Luke's Health System is an Equal Opportunity Employer. Services are provided on a nondiscriminatory basis.

Patient Registration Form

(Please Print)

Patient Demographics:

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ Sex: Male Female SSN: _____

Nick Name/Alias: _____ Address: _____

City/St/Zip: _____ County: _____

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

Email: _____

Birth Place: _____ United States Citizen: Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Other

Patient Language: English Spanish Other _____ Interpreter Needed: Yes No

Ethnic Origin: Am Indian Asian Black White Islander Hispanic Multi-Racial Other _____

Religion: _____ Place of Worship: _____ Education: _____

Patient Primary Care Physician Information:

Primary Care Physician: _____ Phone: _____

Practice Location/Address: _____

Patient Employment Information:

Employment Status: Full Time Part Time Self-Employed Full Time/Student Part Time/Student
Military Duty Not Employed Disabled Retired

Employer: _____

Preferred Communication(s):

No Preference

- Do Not Contact
- Mail
- Phone
- MySaintLukes/ Sign me up for MySaintLukes online patient portal



Consent Form

**Saint Luke's Health System
Saint Luke's Physician Group**

Informed Consent for Mental Health Evaluation and/or Treatment

Patient name: _____ **DOB:** _____

Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by providers from Saint Luke's Psychiatry. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

- a. The benefits of the proposed treatment
- b. Alternative treatment modes and services
- c. The manner in which treatment will be administered
- d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
- e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a licensed therapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at Saint Luke's Psychiatry, and I consent to disclosure for use by Saint Luke's Psychiatry providers for the purpose of continuity of my care. Per Missouri mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect of vulnerable populations arise; or 3) if a court order is issued to obtain records. I also authorize the System to review my medical records to gather data for research purposes. I understand that no information that will identify me in any way will be published. I also consent to the sharing of my health information within the Saint Luke's Health System for the purposes of treatment, payment, and healthcare operations.

Patient Label:



**Saint Luke's Health System
Saint Luke's Physician Group**

Informed Consent for Mental Health Evaluation and/or Treatment

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing. I acknowledge that no guarantee has been made to me as to the results. I hereby authorize the providers of Saint Luke's Psychiatry and whomever he/she may designate as his/her legal representative to conduct the evaluation and/or treatment.

DATE: _____ TIME: _____ A.M. P.M.

Where patient is incapable of signing and another person signs in his stead, fill in the following information:

State why patient is not able to give consent personally (or to sign this form).

Explain: Minor Unconscious Other

Signature of witness Date Time

Signature of witness Date Time
(Phone permission requires two witnesses)

Patient/Other legally responsible signature Date Time

Relation of signer to patient: _____

Address of Witness(es): _____

Prior to the time of the treatment above described, I explained to the patient named above and to any person who has consented to the treatment on the patient's behalf, the nature, purpose, benefits, and risks of the treatment as stated as well as possible alternative methods of treatment. I have further discussed possible consequences of the treatment, the principal risks involved, and possible complications.

Physician/Provider Date Time

Patient Label:



Saint Luke's Health System

Assignment of Benefit Release

I hereby assign to Saint Luke's Health System (SLHS) my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to SLHS. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering services provided by SLHS.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature: _____ Date: _____ Time: _____
(Signature of Patient or Parent, Legal Guardian or Representative)

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, BILLING, OR HEALTH CARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that SLHS reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize SLHS to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or any part of my medical record for the purpose of my treatment, billing, or pertinent health care operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

CONSENT TO CONTACT

By providing my cell, landline, or other contact number(s), I consent to receive communications from SLHS, its staff, contractors, and collection agents, at any numbers I provide or later acquire. These parties may contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message(s), or by other electronic communication for purposes including, but not limited to, appointment and follow-up health care reminders, scheduling, assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for such calls or text messages. I understand that my consent to receive such calls or texts is not a condition of receiving healthcare services.

Patient's Printed Name: _____

Patient's Date of Birth: _____

Minor Patient: Yes No

Signature: _____ Date: _____ Time: _____
(Patient or Legal Representative Signature)

Signature: _____ Date: _____ Time: _____
(Witness)

Patient Label:



Consent MHC

Saint Luke's Health System

Health Information Exchange Network Consent

Please carefully read these statements: *(If you are a patient's legal representative, "me," "my" or "I" refers to the patient)*

By signing this form, I understand and agree that Saint Luke's Health System participates in one or more health information exchange networks. I understand and agree that the health information networks, all health care providers, and other health-related organizations, including payors, that participate in the health information exchange networks:

1. Will be able to see all of my health records from both before and after today's date.
2. May use or share my health information for treatment, payment, and health care operations purposes, but only as allowed by federal and state laws. This is the same as for my health records in paper form and only authorized health care professionals or others involved in your treatment or payment for your treatment will have access to your medical records.
3. May share all of my health records through the health information exchange network; including but is not limited to illnesses or injuries (like diabetes or a broken bone), test results (like X-rays or blood tests), and medicines that I am taking or have taken. This also may include, but is not limited to sensitive information such as **Alcohol or substance abuse problems, Genetic (inherited) diseases or tests, HIV/AIDS, Mental health and developmental disabilities, Head and spinal cord injuries, Family planning information (including abortions), and Sexually transmitted diseases.** May copy/include my health information in their records. Under current law, even if I later cancel my consent, such providers or organizations are not required to remove my health information from their records.
4. Have penalties in place for anyone sharing my information in the wrong way.
5. The health information exchange networks will keep track of who views my health records to make sure they are secure. I can ask my doctor or the health information exchange network for a list of who has looked at my records and if I suspect or learn that my data was shared or accessed in the wrong way, I should contact Saint Luke's Health System immediately.
6. I understand and agree that it may take up to five business days to process my decision regarding the sharing of my electronic health records with the health information exchange.
7. Using my health information for marketing or advertising purposes, or to determine employment eligibility is strictly prohibited.
8. My consent will remain in effect until the day I cancel my consent by "Opting Out" or the health information exchange network no longer exists, whichever comes first. To opt-out of the health information exchange networks in which Saint Luke's Health System participates, I must complete a form found at each of the following websites:
 - Missouri Health Connection: <http://www.missourihealthconnection.org>
9. ***I am not required to sign this form.*** Saint Luke's Health System will continue to treat me even if I do not sign this form. My consent to share my records with a Health Information Network is voluntary and I may ask for a copy of this form after I sign it.

By signing this form, I give all participating health care providers and other organizations in health information exchange networks in which, Saint Luke's Health System, participates the right to share all my health records, including sensitive data, through the relevant health information exchange network and that the health information exchange will share my health information with providers and others who are treating me or involved in the provision or payment of my care. *(* If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will need to provide his or her consent to share records with a health information exchange network.)*

Patient Full Name (Print)

Name of Legal Representative

Patient Signature

Signature of Legal Representative's Signature

Date of Signature

Time of Signature

Patient Date of Birth

Patient Label:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

TOTAL:

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

Initial Health History Packet

Saint Luke's Psychiatry-Plaza

4225 Baltimore Ave,
Kansas City, Mo 64111
816-932-1711

GENERAL INFORMATION

Name: _____ DOB: _____

Education level: _____

Reason for visit: _____

Referring doctor: _____

PSYCHIATRIC & MEDICAL HISTORY

Please check any current or past diagnoses given by a clinician:

ADHD/ADD	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>
Anorexia nervosa	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	OCD	<input type="checkbox"/>
Autism spectrum disorder	<input type="checkbox"/>	ODD (Oppositional defiance disorder)	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	Panic disorder	<input type="checkbox"/>
Borderline personality disorder	<input type="checkbox"/>	Psychosis	<input type="checkbox"/>
Bulimia nervosa	<input type="checkbox"/>	PTSD	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Schizoaffective disorder	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Other, please specify: _____			

Please list any past or current psychiatrist/s, psychologist/s or mental health provider/s (name/address/phone number):

Please list any other doctor/s or specialist/s you see regularly (name, address, phone number):

Please list any family members that been diagnosed with any mental illness, substance abuse disorder, dementia or neurologic disorder. Please specify if family member is maternal or paternal if applicable.

Please check any psychiatric medications you have taken in the past. If checked, please indicate years taken and effect.

Medication	Years Taken	Effect
Antidepressants		
Anafranil (Clomipramine)	<input type="checkbox"/>	
Torfranil (Imipramine)	<input type="checkbox"/>	
Desyrel (Trazodone)	<input type="checkbox"/>	
Amytriptyline (Elavil)	<input type="checkbox"/>	
Nortriptyline (Pamelor)	<input type="checkbox"/>	
Norpramin (Desipramine)	<input type="checkbox"/>	
Doxepin	<input type="checkbox"/>	
Celexa (Citalopram)	<input type="checkbox"/>	
Lexapro (Escitalopram)	<input type="checkbox"/>	
Zoloft (Sertraline)	<input type="checkbox"/>	
Paxil (Paroxetine)	<input type="checkbox"/>	
Prozac (Fluoxetine)	<input type="checkbox"/>	
Luvox (Fluvoxamine)	<input type="checkbox"/>	
Viibryd (Vilazodone)	<input type="checkbox"/>	
Nefazodone	<input type="checkbox"/>	
Effexor (Venlafaxine)	<input type="checkbox"/>	
Pristiq (Desvenlafaxine)	<input type="checkbox"/>	
Savella (Milnacipran)	<input type="checkbox"/>	
Cymbalta (Duloxetine)	<input type="checkbox"/>	
Wellbutrin/Zyban (Bupropion)	<input type="checkbox"/>	
Remeron (Mirtazepine)	<input type="checkbox"/>	
Marplan (Isocarboxazid)	<input type="checkbox"/>	

Nardil (Phenelzine)			
Parnate (Tranlylcypromine)			
Em Sam (Selegiline)			
Anti-Anxiety			
Buspar (Buspirone)			
Neurontin (Gabapentin)			
Atarax/Vistaril (hydroxyzine)			
Ativan (Lorazepam)			
Xanax (Alprazolam)			
Klonopin (clonazepam)			
Valium (Diazepam)			
Librium (Chlordiazepoxide)			
Pindolol			
Inderal (Propranolol)			
Tenex/Intuniv (Guanfacine)			
Clonidine/Kapvay,(Catapres)			
Antipsychotics			
Abilify (Aripiprazole)			
Saphris (Asenapine)			
Clozaril (Clozapine)			
Fanapt (Iloperidone)			
Latuda (Lurasidone)			
ZYprexa (Olanzapine)			
Invega (Paliperidone)			
Seroquel (Quetiapine)			
Risperdal (Risperidone)			
Chlorpromazine (Thorazine)			
Haldol (Haloperidone)			
Loxapine (Loxitane)			
Thioridazine (Mellaril)			
Mood Stabalizers			
Lithium (Eskalith)			
Depakote (Valproic Acid)			
Tegretol (Carbamazepine)			
Trileptal (Oxcarbazepine)			
Lamictal (Lamotrigine)			
Topamax (Topiramate)			
Neurontin (Gapapentin)			
Dilantin (Phenytoin)			

Stimulants/ ADHD Meds			
Provigil			
Nuvigil			
Adderall (Amphetamine)			
Vyvanse			
Ritalin			
Concerta/Metadate			
Sleep Medications			
Ambien (Zolpidem)			
Lunesta (Eszopiclone)			
Pro-Som (Estazolam)			
Resotril (Temazepam)			
Sonata (Zaleplon)			
Trazodone (Desyrel)			
Rozerem (ramelteon)			
Over the counter or herbal supplements:			
Tylenol PM			
Melatonin			
Fish oil/Oemga-3 fatty acids			
St. John's Wort			
SamE			
5HTP			
Other			
Dementia/Cognitive			
Aricept (Donezpril)			
Excelon			
Namenda (Memantine)			

Please indicate if you are currently experiencing any of the following:

General				Genitourinary		
Appetite loss	Yes	No		Pain with urination	Yes	No
Weight loss/gain	Yes	No		Frequent urination	Yes	No
Fever/Chills	Yes	No		Difficulty starting or maintaining urine stream	Yes	No
				Sexual difficulties	Yes	No
EENT						
Hearing loss	Yes	No		Musculoskeletal		
Vision change	Yes	No		Muscle pain	Yes	No
Nasal congestion	Yes	No		Joint pain	Yes	No
Trouble swallowing	Yes	No		Back pain	Yes	No

Ears, nose, mouth, throat, and face				Musculoskeletal		
Ear drainage	Yes	No		Joint pain	Yes	No
Earaches	Yes	No		Back pain	Yes	No
Bloody nose	Yes	No		Bone pain	Yes	No
Facial trauma	Yes	No		Muscle weakness	Yes	No
Hearing loss	Yes	No		Muscle pain	Yes	No
Hoarseness	Yes	No		Neck pain	Yes	No
Nasal congestion	Yes	No		Stiff joints	Yes	No
Snoring	Yes	No				
Sore mouth	Yes	No		Genitourinary		
Sore throat	Yes	No		Abnormal menstrual periods	Yes	No
Ear ringing	Yes	No		Genital lesions	Yes	No
Voice change	Yes	No		Hot flashes	Yes	No
				Sexual problems	Yes	No
Respiratory				Vaginal discharge	Yes	No
Asthma	Yes	No		Decreased stream	Yes	No
Chronic bronchitis	Yes	No		Pain with urination	Yes	No
Cough	Yes	No		Frequency	Yes	No
Shortness of breath on exertion	Yes	No		Blood in urine	Yes	No
Emphysema	Yes	No		Trouble starting urination	Yes	No
Bloody cough	Yes	No		Wetting the bed	Yes	No
Chest pain with deep breath	Yes	No		Urinary incontinence	Yes	No
Pneumonia	Yes	No				
Cough with phlegm	Yes	No		Neurological		
Wheezing	Yes	No		Coordination problems	Yes	No
Wheezing	Yes	No		Dizziness	Yes	No
				Gait problems	Yes	No
Integument/breast				Headaches	Yes	No
Breast lump	Yes	No		Memory problems	Yes	No
Breast tenderness	Yes	No		“Pins and needles”	Yes	No
Changed mole	Yes	No		Seizures	Yes	No
Dryness	Yes	No		Speech problems	Yes	No
Nipple discharge	Yes	No		Tremors	Yes	No
Itchiness	Yes	No		Vertigo	Yes	No
Rash	Yes	No		Weakness	Yes	No
Skin color change	Yes	No				
Skin lesion(s)	Yes	No		Endocrine		
				Blurry vision	Yes	No
Hematologic/lymphatic	Yes	No		Increased fatigue	Yes	No
Bleeding	Yes	No		Increased thirst	Yes	No
Easy bruising	Yes	No		Increase appetite	Yes	No
				Urinating often	Yes	No
Allergic/Immunologic				Poor wound healing	Yes	No
Hay fever	Yes	No		Skin dryness and weight loss	Yes	No
Hives	Yes	No		Fertility problems	Yes	No
				Getting hot/cold easily	Yes	No

SOCIAL HISTORY

Tobacco use history

Smoke tobacco (Check one):

Current every day smoker	<input type="checkbox"/>	Never smoker	<input type="checkbox"/>
Current some days smoker	<input type="checkbox"/>	Passive smoke exposure-never smoker	<input type="checkbox"/>
Former smoker	<input type="checkbox"/>		<input type="checkbox"/>

If current or past smoker:

Start date: _____ Quit Date: _____

Type: _____ Packs/day: _____ **Smokeless tobacco (Check one):**

Never used	<input type="checkbox"/>	Current user	<input type="checkbox"/>	Former user	<input type="checkbox"/>	Quit Date:	<input type="checkbox"/>
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Alcohol use history

Alcohol use (Circle one):

Yes	No
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If yes, please indicate amount:

Drinks	Number Per Week
Glasses of wine	
Cans/bottles of beer	
Shots of liquor	
Standard drinks	

Substance use history

Drug use (Circle one):

Yes	No
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If yes, indicate types: _____

If yes, indicate use per week: _____

Sexual history

Sexually active (Circle one):

Yes	No	Not currently
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If yes, indicate birth control/protection: _____

If yes, circle partner/s:

Female	Male
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