

Saint Luke's Behavioral Health Specialists

Your upcoming appointment will be with _____.

Saint Luke's Behavioral Health Specialists 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 Behavioral Health Specialists Office Policy

Office Hours and Appointments

- This office is open **Monday through Friday from 8:15am to 4:30pm**. If you are unable to keep your scheduled appointment, please call **816-932-1711** at least 24 hours prior to your appointment time. Please update our office staff of any changes of address, phone number, or insurance coverage prior to your visit or upon arrival.
- Any new patient who fails to show for their initial visit or who cancels their appointment with less than 24 hours' notice will not be rescheduled without a new referral (patients are limited to two referrals in a rolling 12 month period).
- We ask that you **arrive 30 minutes prior** to your initial visit appointment to allow time for check-in and to complete the pre-appointment process (vitals, questionnaires, etc).
- If you arrive more than 15 minutes after the scheduled time for your appointment, you may be asked to reschedule and recorded as a missing the appointment.

Co-Payment Collections

- All co-payments and payments towards any deductibles are expected at the time of service. If you do not provide current and accurate insurance information for each visit you may be financially responsible for those services provided. If you have a concern about your financial obligation, please contact the office prior to the day of your appointment to discuss.
- There may be additional fees for completing forms, such as disability or FMLA requests.

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: _____

Preferred Name: _____ 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 Group: Hispanic or Latino Not Hispanic or Latino Decline

Race: American Indian or Alaska Native Asian Black or African American White or Caucasian

Native Hawaiian or Other Pacific Islander Other Decline

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: _____



**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 Behavioral Health Specialists. 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 Behavioral Health Specialists, and I consent to disclosure for use by Saint Luke's Behavioral Health Specialists 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 Behavioral Health Specialists 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

Protected Health Information – Communication Preferences

Please communicate preferences about my health care with me in the following manner: (Check all that apply.)

- My home telephone number is:
Ok to leave a message with detailed information
Ok to leave a message with call-back information only
My work telephone number is:
Ok to leave a message with detailed information
Ok to leave a message with call-back information only
My cellular telephone number is:
Ok to leave a message with detailed information
Ok to leave a message with call-back information only
Written communication
Ok to mail to my home address:
Ok to mail to my work/office:
MySaintLuke's patient portal

Check applicable box:

- I was offered and made available, but I am electing not to receive a copy of SLHS Notice of Privacy Practices.
I acknowledge receiving a copy of SLHS Notice of Privacy Practices.

You may discuss detailed information about my healthcare needs with the following individual(s):

Table with 3 columns: Name of individual, Telephone number, Relationship to patient. Rows 1 and 2.

Patient name: Birthdate: Patient Account #:

You will be asked to review and update your preferences on a yearly basis. You may change your preferences or withdraw permission for the individuals indicated above at any time by contacting your Saint Luke's provider. Your communication preferences applies to all providers and facilities within Saint Luke's Health System.

Note: These preferences do not apply to behavioral health visits. These preferences ONLY apply to the Saint Luke's Behavioral Health Specialists Clinic.

Signature of patient or personal representative* / Date / Time

*If signed by a personal representative, the following information must also be included: Name of personal representative and description of their authority to act on behalf of patient:

Patient Label:

Saint Luke's Health System

Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT I consent to and authorize Saint Luke's Health System's entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. At the discretion of the professional staff, I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs, or other images, of me or parts of my body to be used in medical evaluations, education or research. I also authorize the use of video/audio technology (e.g. eICU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of the Entity to be used in medical evaluations, education or research.

PROFESSIONAL CARE The patient is under the professional care of an attending physician who arranges for services in the care and treatment of the patient. I realize that those who provide patient care at this Entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the release of all or any part of the patient's medical and accounting record which may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the Entity. 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.

ASSIGNMENT OF BENEFITS I hereby assign to Saint Luke's Health System's entities and any or all physicians; all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the Entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to notify the Entity directly of the determination of such grievances or appeals.

FINANCIAL RESPONSIBILITY In consideration of the Entity and the physicians supplying or furnishing hospitalization, Entity services and physician services; I promise to pay the Entity and the physicians for such hospitalization, Entity services and physician services supplied and furnished heretofore or to be supplied and furnished to said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the Entity and physicians for the charges not covered by the policy of the insurance or self-insured health plan. I also understand, pursuant to the hospital lien statutes of this state, if my injuries were caused by the negligence or wrongful act of another, Saint Luke's Health System may have a lien on any and all claims or rights of action I may have against the person causing my injuries, and Saint Luke's Health System may have the right to enforce the lien for payment of services rendered rather than seek payment from my insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs shall be included as part of the obligation due Saint Luke's Health System's entities and physicians. Any correspondence or payments regarding disputed debts, or any payments that purport to be payments in full satisfaction of the debt owed, must be sent to Saint Luke's Health System Centralized Business Office at 901 E. 104th St., Kansas City, MO 64131.

FINANCIAL ASSISTANCE The hospital has a financial assistance policy for which you may qualify. The income guidelines are based on Federal Poverty Limits. If your income is less than the guideline for your family size, you may qualify for assistance.

GENERAL TERMS

Behavior Expectation: I agree that it is my responsibility to treat other patients, visitors and staff with respect. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Patient Label:

Saint Luke's Health System

Consent and Agreement of Health Care Services

Consent to Contact: I consent to receive communications from SLHS, its contractors and collection representatives on any phone number I provide or later acquire (cell or landline). I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. Contacts may be via live agent, voicemail, text message, auto dialer or other technology. I understand depending on my phone plan I may be charged for calls or text messages. I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.

Exit agreement: I have been informed and agree that I will voluntarily exit from Saint Luke's Health System when it is determined in the medical judgment of my physician or the Hospital's Utilization Review Committee that I no longer need to remain under care.

Release of responsibility for valuables: I understand the Hospital strongly recommends that all personal belongings and valuables be sent home or placed in the hospital's security for safekeeping until discharge. I understand the Hospital shall not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

Tobacco free policy: I understand that all Saint Luke's Health System campuses are tobacco free. I acknowledge that I may not smoke or use any tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold the Entity or any of its employees or agents responsible if I am injured in any way because of my decision to smoke or use tobacco products. Minors will follow state and Federal laws regarding smoking. This tobacco free policy applies to e-cigarettes, vaping products and other alternative tobacco and nicotine products.

Patient satisfaction survey: Saint Luke's Health System may contact you regarding the care you received and use this information to improve the quality of care we deliver. This survey may be provided via a telephone call or by email with a link to a secure website where you may provide anonymous input. You may also receive an email from MySaintLuke's inviting you to enroll in our online patient portal, where you can securely communicate with your physician, get lab results and visit summaries, and more.

I also agree I have received or have been offered information on the topics listed below through signs, packets and/or brochures, which contain information about:

- Advanced Directives
- Patient Advocacy/Patient Rights/Grievance Procedure information
- Financial Assistance policy (FAP) Summary
- Notice of Privacy Practices
- Interpretive services
- Skilled Nursing Welcome Letter and Grievance Procedure (as applicable)

I/We hereby certify that I/we have read all parts of this Consent and Agreement and accept all terms and conditions and state that all representations made by me are true.

Print Name of Patient

Signature of Patient or Authorized Representative (include Relationship to patient) **Date** **Time**

If patient is unable to sign, explain:

Minor Critical nature of illness Other: _____

If the patient is unable to sign and there is no Authorized Representative available OR if consent is being obtained via telephone, two witnesses are required.

Signature of Witness 1 Date/Time

Print Witness 1 Name

Signature of Witness 2 Date/Time

Print Witness 2 Name

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:

Initial Health History Packet

Saint Luke's Behavioral Health Specialists

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		HIV/AIDS	
Alcoholism		Liver disease	
Anorexia nervosa		Neuropathy	
Anxiety		OCD	
Autism spectrum disorder		ODD (Oppositional defiance disorder)	
Bipolar disorder		Panic disorder	
Borderline personality disorder		Psychosis	
Bulimia nervosa		PTSD	
Cancer		Schizoaffective disorder	
Chronic pain		Seizures	
Depression		Substance abuse	
Head injury		Thyroid disease	
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
-----	----

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
-----	----

If yes, indicate types: _____

If yes, indicate use per week: _____

Sexual history

Sexually active (Circle one):

Yes	No	Not currently
-----	----	---------------

If yes, indicate birth control/protection: _____

If yes, circle partner/s:

Female	Male
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**To be filled out
by patient
ONLY**

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 figety 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:

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?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

To be filled out
by patient
ONLY

GAD-7

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

Not
at all

Several
days

More than
half the
days

Nearly
every day

(Use "✓" to indicate your answer)

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 ____ = ____ + ____ + ____)