

Today's Date (month/day/year)		Preferred Name	
First Name		Last Name	
Social Security Number		Date of Birth (month/day/year)	
Home Address			
City		State	Zip Code
Phone Number		Alternate Phone Number	
Email Address			

Patient Demographics	
Legal Sex <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Unknown <input type="checkbox"/> X	
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary / Genderqueer <input type="checkbox"/> Transgender Male / Trans Man / FTM <input type="checkbox"/> Transgender Female / Trans Woman / MTF <input type="checkbox"/> Questioning <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other <input type="checkbox"/> Choose Not To Disclose	Sexual Orientation <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Queer <input type="checkbox"/> Gay <input type="checkbox"/> Something Else <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Asexual <input type="checkbox"/> Choose Not to Disclose / Decline <input type="checkbox"/> Omnisexual
Patient's Sex Assigned at Birth <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown <input type="checkbox"/> Not Recorded on Birth Certificate <input type="checkbox"/> Choose Not To Disclose	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
What is your ethnicity? <input type="checkbox"/> Non-Hispanic or Latino/a <input type="checkbox"/> Mexican, Mexican American, or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Don't Know <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Multiple Hispanic, Latino/a or Spanish Origins <input type="checkbox"/> Choose Not To Disclose	
What is your race or biological family background? <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Choose Not To Disclose <input type="checkbox"/> Don't Know	

Emergency Contact	
Name	
Phone Number	Relationship to Patient
Employment	
Employment Status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed	
Language	
Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No My preferred language is _____
English Fluency <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Not Good <input type="checkbox"/> Not at All	
Preferred Written Language	Preferred Language Spoken

Additional Demographics	
Are you experiencing homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No (Not Homeless) <input type="checkbox"/> Currently Not Homeless (was in the last 12 months)	
If Yes, please choose one (1) below <input type="checkbox"/> Living in Shelter (Homeless Shelter) <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Living with Others (Doubling Up) <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> Homeless Unknown Shelter <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Single Occupancy Hotel (Other) <input type="checkbox"/> At Risk for Homelessness <input type="checkbox"/> At Risk for Homelessness (Child) <input type="checkbox"/> At Risk for Homelessness (Veteran)	
Are you a migrant / seasonal worker? <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Neither	
Veteran / Military Status <input type="checkbox"/> Yes <input type="checkbox"/> No, I am not a veteran (or served in the military)	
Country of Origin (optional) _____	

Would you like assistance during your appointment?

- Yes, support for Low Vision or Blindness.
- Yes, Hard of hearing.
- Yes, Mobility Assistance (please describe) _____
- Yes, other (please describe) _____

What pronouns do you use?

- She / Her / Hers He / Him / His They / Them / Theirs Ze / Hir / Hirs Ey / Em / Eirs Xe / Xem / Xyrs
- Ve / Vir / Virs Other Patient's Name Unknown Decline to Answer

Communication Preferences (Circle all that apply)

How would you like to be contacted for Appointments?	Phone	Text	Email	Mail
Billing Issues	Phone	Text	Email	Mail
Healthcare Questions / Results	Phone	Text	Email	Mail
Messages from Your Provider	Phone	Text	Email	Mail
Other Communication	Phone	Text	Email	Mail

Guarantor Information

- Self
- For children - name of parent or legal guardian _____ Day of Birth (month/day/year) _____
- Address (if different from patient's) _____ City _____ State ____ ZIP Code _____
- Relationship to Patient _____

Total number of people in your household (you and your dependents) _____

- What is your household income before taxes \$ _____ Hourly Weekly Monthly Annual
- Choose Not to Disclose

Note: I understand that if I choose not to disclose my household income and number of people in my household, I decline participation in Elica's financial assistance program (Sliding Fee). If my circumstances change, or if I change my mind, I know that I can ask a staff member for an application.

Insurance

Medicare Member ID Number _____ Effective Date _____

Medicaid Member ID Number _____ Effective Date _____

1. Give receptionist your insurance card and ID to scan in your chart
2. Turn in sliding fee application and proof of income for sliding scale (if self-pay)

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Print Name of Patient

Relationship to Patient of Individual Signing Form
(for example: patient, parent, guardian)

Patient / Guardian Signature

Date

Consents & Acknowledgements

Treatment: I agree to receive treatment from Elica's providers and staff. I know that a medical record will be created about me. I can get a copy of my record by signing a Medical Records Authorization Form provided by the clinic.

Telehealth: I agree to receive care via telephone, telehealth, or the patient portal when medically necessary and clinically appropriate for exchanging medical information with my providers. Elica's providers can only legally treat patients located in California. Telehealth services cannot be provided to anyone currently outside of California for any reason.

Students / Residents: I understand that Elica is involved with the education of healthcare students. This means that students or residents may be present during visits for myself, my child, or the individual for whom I am a guardian. I understand that, under supervision of licensed healthcare providers, students or residents may assist with caring for myself, my child, or the individual for whom I am a guardian. I am aware that I can decline their participation in care at any time, and that this will not affect access to care.

Assignment of Benefits: I hereby assign all rights and benefits under my insurance policy to Elica allowing them to directly submit claims and receive payment from my insurance company on my behalf. I understand I am responsible for paying any charges my insurance doesn't cover, including the balance after discounts.

Photographs: I agree that Elica may take a photograph of myself, my child, or the individual for whom I am a guardian, for identification purposes in the health record. If I decline to have this photograph taken, I understand my legal photo ID may be used instead.

Patient Pharmacy Free Choice: I understand that I have the freedom to choose my pharmacy. Prescriptions will be sent to my pharmacy of choice. If eligible, I may be referred to a specific pharmacy for free or discounted medications. If I choose a different pharmacy, I may have to pay the full price.

Notice of Privacy Practices: I agree I was informed or have received a copy of Elica's Notice of Privacy Practices. I may access a copy of this at any time on Elica's website (www.elicahealth.org).

Health Information Exchange: Elica is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Elica, OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. I understand that health information may be shared by Elica with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement.

BY SIGNING BELOW, I CONFIRM I HAVE READ THE CONSENT SECTION, AND UNDERSTAND AND ACCEPT ITS TERMS.

Print Name of Patient

Relationship to Patient of Individual Signing Form
(for example: patient, parent, guardian)

Patient / Guardian Signature

Date

Elica Health Centers is committed to protecting your health information. This **HIPAA disclosure/non-disclosure form** allows you to add, update, or change how your protected health information is shared. This form helps us understand any new instructions you have about what details, if any, you would like us to share with the people in your life. Elica providers will only communicate with patients regarding their treatment or care in person, telephonically, or via the patient portal.

Patient Information			
Last Name:	First Name:	Middle Initial:	Date of Birth:

Communication Preferences: Type of communication you prefer and what we can share (data rates may apply)					
	Mail	Phone	Text	Email	Portal
To Do			<input type="checkbox"/>	<input type="checkbox"/>	
News and Announcements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Questionnaires				<input type="checkbox"/>	
Account Management			<input type="checkbox"/>	<input type="checkbox"/>	
Telehealth				<input type="checkbox"/>	
Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Messages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.

<p>Person #1 First and Last Name: _____ Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____ <input type="checkbox"/> We can tell this person any and all of your medical information. OR <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.</p>	<p>Person #2 First and Last Name: _____ Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____ <input type="checkbox"/> We can tell this person any and all of your medical information. OR <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.</p>
<p>Person #3 First and Last Name: _____ Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____ <input type="checkbox"/> We can tell this person any and all of your medical information. OR <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.</p>	<p>Person #4 First and Last Name: _____ Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____ <input type="checkbox"/> We can tell this person any and all of your medical information. OR <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.</p>

I do not want ANYTHING told or shared with ANYONE.

By signing this **HIPAA disclosure/non-disclosure form**, I authorize Elica Health Centers to update and share my health information according to the changes I have indicated above. This authorization supersedes any previous authorizations I have provided to share my protected health information, and applies only to the information and individuals listed on this form.
 This authorization will expire **1 year from the date of signing** or upon (describe terminating event): _____.

Print First and Last Name of Patient	Relationship to Patient (e.g., self, parent, guardian)
Patient / Guardian Signature	Date

OFFICE USE ONLY	
Effective Date: _____	Updated By: _____

ADULT & PEDIATRIC AGE 12+ HEALTH HISTORY

Patient Name:	Date of Birth:
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We ask everyone about their reproductive health needs.
 Pregnancy Intention Screening Questions

Are you currently pregnant? Yes No

What was the first day of your Last Menstrual Period, if menstruating? Date: _____ N/A

Are you currently breastfeeding? Yes No

Do you want to become Pregnant? Yes No Unsure Ok either way N/A

Do you want to talk about contraception or pregnancy prevention today? Yes No

ALLERGIES TO ANY MEDICATIONS, FOOD OR OTHER SUBSTANCES?

Allergic to:	Reaction:	Severity of Reaction:
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

MEDICAL HISTORY (Check all diseases and medical conditions that apply)

No Past Medical History

<input type="checkbox"/> Abuse as Adult (victim)	<input type="checkbox"/> Depression	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Abuse as a child (victim)	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Myocardial infarction
<input type="checkbox"/> Anemia	<input type="checkbox"/> GERD	<input type="checkbox"/> Nerve/Muscle disease

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis / Joint disorder	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/> TB disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Other, please explain:		

SURGICAL HISTORY		
<input type="checkbox"/> No Past Surgical History		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Small intestine surgery
<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Eye surgery	<input type="checkbox"/> Spine surgery
<input type="checkbox"/> Breast surgery	<input type="checkbox"/> Fracture surgery	<input type="checkbox"/> Third Molar Extraction
<input type="checkbox"/> CABG	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Valve replacement
<input type="checkbox"/> Colon surgery	<input type="checkbox"/> Prostate surgery	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Other, please explain:		

FAMILY HISTORY (Check all diseases and conditions that apply):

		No Known Problems	Alcohol/Drug Use	Allergies	Alzheimer's Disease	Anemia	Autoimmune Disease	Breast Cancer	Colon Cancer	Cancer	Depression	Diabetes	Heart Attack	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Stroke	Sudden Death	Suicide	Thyroid Disease	Vision Problems	Other
Relationship	Name																							
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								
Maternal Aunt																								
Maternal Uncle																								
Paternal Aunt																								
Paternal Uncle																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								
Other																								

LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:

Disease or medical problem:	Family member:

TOBACCO USE

Do you use E-Cigarettes or Vape any substances?

- Never used
 Former user, quit date: _____
 Yes, every day
 Yes, some days

If yes, what substance? Nicotine THC CBD Flavoring Other: _____

Do you smoke any tobacco products? (cigarettes, cigars, etc)

Never used Former user, quit date: _____ Yes, every day Yes, some days

Do you use any smokeless tobacco? (chew, snuff, dissolvables, etc)

Never used Former user, quit date: _____ Yes

Are you, or have you been in the past, regularly exposed to smoke? (Passive exposure)

Never Past Current

ALCOHOL INTAKE

Do you ever drink alcohol? Yes Not currently No

How many drinks per week, and of what? _____ drinks of _____ per week

DRUG USE

Do you currently (in the last 6 months) any recreational drugs? Yes Not currently No

Which drugs do you use? Vaping Marijuana Opioids (Fentanyl, Codeine, Oxy, Norco, etc) Heroin
 Methamphetamine Amphetamines (Adderall) PCP Ecstasy (MDMA, Molly) LSD (Acid) Ketamine
 Mescaline (Peyote) Psilocybin (Magic Mushrooms, 'Shrooms) Cocaine Crack Nitrous Oxide Solvent Inhalants
(Poppers, etc) Barbiturates Benzodiazepines (Xanax, Ativan, Klonopin) IV use (Needle to inject drugs)
 Other: _____

SEXUAL ACTIVITY

Sexually active: Yes Not Currently Never

Birth Control / Protection: Abstinence Cervical Cap Condom Diaphragm Fertility Awareness Method Hormonal Patch

Implant Injection Inserts I.U.D IUS Menopause Pill Rhythm Spermicide Sponge Surgical

Vaginal Ring Vasectomy Withdrawal None

Partners: Male Female Transgender Female / Male-to-Female Transgender Male / Female-to-Male

Non-binary / genderqueer Questioning Other Choose not to disclose

Comments: _____

PREGNANCY (OBSTETRIC) HISTORY

Have you ever been pregnant? Yes No N/A

If yes, how many times TOTAL have you been pregnant? _____ (Gravida)

- How many babies have you delivered? _____ (Para)

- How many babies were full term? (37 weeks or more) _____ (Term)

- How many babies were premature (less than 37 weeks) _____ (Preterm)

- How many living children do you have? _____ (Living)

- How many miscarriages have you had? _____ (SAB)

- How many abortions have you had? _____ (IAB)

Have you ever had any pregnancy or birth complications? _____

AUDIT

<p>1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p>	<p>7. How often during the last year, have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</p>	<p>8. How often during the last year, have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>4. How often during the last year, have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>	<p>9. Have you or someone else been injured as a result of your drinking? (0) No (1) Yes, but not in the last year (2) Yes, but during the last year</p>
<p>5. How often during the last year, have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (1) Yes, but not in the last year (2) Yes, but during the last year</p>

DAST

These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you abuse more than one drug at the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you always able to stop using drugs when you want to? (If never used drugs, answer "Yes.")	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you had "blackouts" or "flashbacks" as a result of drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you neglected your family because of your use of drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you engaged in illegal activities in order to obtain drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever experienced withdrawal symptoms (feel sick) when you stopped using drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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PHQ-9

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	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

TB RISK ASSESSMENT

Recent close or prolonged contact with someone with infectious TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Born in or recent traveler to high prevalence area (see flowsheet sidebar for country list)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest radiographs with fibrotic changes suggesting inactive or past TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ transplant recipient	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppression secondary to use of prednisone (equivalent of > or = to 15mg/day for >or = 1 month) or other immunosuppressive medication such as TNF -o antagonist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injection drug user	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Resident or employee of high-risk congregate setting (e.g., prison, long-term care facility, hospital, homeless shelter)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical condition associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's Disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population))	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signs/Symptoms of TB <input type="checkbox"/> Cough lasting <input type="checkbox"/> Persistent fever <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Persistent sweats <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain <input type="checkbox"/> None		

SOCIAL HISTORY (PRAPARE)

What is the highest grade or year of school you completed?

Never attended school or only attended kindergarten
 Grades 1 through 8 (Elementary)
 Grades 9 through 11 (Some high school)
 Grade 12 or GED (High school graduate, diploma, or alternative credential)
 College 1 year to 3 years (Some college, Associate's degree, trade, vocational school)
 College 4 years or more (College Graduate)
 Declined

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?

Not hard at all
 Somewhat hard
 Very hard
 Decline

What is your living situation today?

I have a steady place to live
 I have a place to live today, but I am worried about losing it in the future
 I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the streets, on the beach, in the car..)
 Decline

In the past 12 months, has lack of transportation kept you from medical appointments, meeting, work or from getting things needed for daily living?

Yes, it has kept me from medical appointments or getting medications
 Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
 No
 Declined

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends in the phone, visiting friends or family, going to church or club meetings)

Less than once a week
 1-2 times a week
 3-5 times a week
 5 or more times a week
 Decline

Do you feel these kinds of stress these days?

Not at all
 A little bit
 Somewhat
 Quite a bit
 Very much
 Decline

Are you currently employed? Yes No Decline

Would you like assistance with any of the above items? Yes No

Type of assistance: Written information Contact me

What do you want help with?

- Health Literacy Education Financial Strain Housing Food Transportation Utilities
 Physical Activities Stress Isolation Relationship Employment

MEDICATION

(List all current medications: prescribed, over-the-counter drugs, vitamins & inhalers and the dosage)

Medication	Dosage	Frequency

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS OR SPECIALISTS?

(LIST ALL BELOW)

Medical Assistant: Complete a medical record release form for all medical providers listed below and add to Care Team in Epic

Physician/Practice Name	Specialty	Address	Phone

DENTAL HISTORY

1. Have you had problems with prior dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Date of last dental exam:		
3. Have you ever been pre-medicated for dental treatment? If yes, why?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you taken bisphosphonates?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALLERGIES AND REACTIONS

Are you allergic to Latex? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to local anesthetic? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to Nitrous oxide? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

