Eva Family Health Clinic

4208 Eva Road, Suite B
Eva, AL 35621
Phone: [256-735-4154] / Fax: [256-735-4054]

Patient Intake Form

Patient Demographics

Name:		DOB:	Date of Intake:
Address:			SS#:
Email:			Phone #:
Leave Message Okay: ☐ Yes ☐ No		Text Reminder Okay: ☐ Yes ☐ No	
Marital Status:	DOB:	Gender:	Ethnicity:
Emergency Contact:		Relationship to You:	
Email:		Phone #:	
Do we have your consent to reach out to your emergency contact any time we are unable to reach you? Yes ____ No ____			

Primary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	
Person Responsible for Account:	

Secondary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	
Person Responsible for Account:	

Medical History

Primary Care Provider:	Phone #:

List all current physicians and/or practitioners you currently use.

Name	Specialty

Current Medical Issues/ Chronic Illness / Diagnosis:

_____

_____

_____

_____

Medications

List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency	Prescribed By

Surgeries/Hospitalizations

Type of Surgery / Hospitalization	Date

Medical Information

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Weight: Height: Appetite: ☐ Good ☐ Fair ☐ Poor

List any vaccines you've had in the last year:

Allergies:

Health Maintenance History			
Yearly Physical	Date:	☐ Normal	☐ Abnormal
Mammogram	Date:	☐ Normal	☐ Abnormal
Colon Cancer Screen	Date:	☐ Normal	☐ Abnormal
Pap Smear	Date:	☐ Normal	☐ Abnormal
Bone Density	Date:	☐ Normal	☐ Abnormal

Women's Health History

Date of Last Menstrual Cycle:		Age of First Menstruation:
Pregnancy Complications:	Possibly Pregnant: ☐ Yes	☐ No
Number of Pregnancies:	Number of Live Births:	Age of Menopause:

Are you currently on any form of birth control, if so, what kind?

Any additional women's health concerns you would like us to know about:

Please check any condition you currently have OR have ever had in the past (include childhood illnesses).

- ☐ None
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Blood Clot
- ☐ Anemia
- ☐ Depression
- ☐ Osteoporosis
- ☐ Pins or Metal Implants
- ☐ Arthritis
- ☐ Epilepsy
- ☐ COPD
- ☐ Anxiety
- ☐ Gout
- ☐ Seizures
- ☐ Hepatitis
- ☐ Stroke
- ☐ Concussion
- ☐ STD
- ☐ Hernia
- ☐ Visual Dysfunction
- ☐ Neurologic Disorder
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Low Blood Pressure
- ☐ Fibromyalgia
- ☐ Pacemaker
- ☐ Heart Problem
- ☐ Infectious Disease
- ☐ Alcoholism
- ☐ Sleep Problems
- ☐ Leg Swelling
- ☐ Breathing Problems
- ☐ Migraines/Headaches
- ☐ Thyroid Trouble
- ☐ Lupus
- ☐ Ulcers
- ☐ High Blood Pressure

Have you experienced any of these symptoms recently? (Check all that apply)

- ☐ Chest Pain
- ☐ Pain with Meals
- ☐ Nausea/Vomiting
- ☐ Poor Balance/Falls
- ☐ Difficulty Swallowing
- ☐ Unusual Pain w/Menstruation
- ☐ Unexplained Weight Gain/Loss
- ☐ Self-Injury
- ☐ Dizziness
- ☐ Vision Changes
- ☐ Memory Problems
- ☐ Unusual Weakness
- ☐ Shortness of Breath
- ☐ Change in Bowel Habits/Control
- ☐ Change in Bladder Habits/Control
- Suicidal Ideation
- ☐ Fever/Chills/Sweats
- ☐ Difficulty Speaking
- ☐ Numbness/Tingling
- ☐ Change in Appetite
- ☐ Confusion/Brain Fog
- ☐ Increased Pain at Night/Rest
- ☐ Other:

Family History

List health problems and causes of death, if applicable:

Relationship to You	Status	Age	Medical Problem
Father	☐ Living ☐ Deceased		
Mother	☐ Living ☐ Deceased		
Father's Father	☐ Living ☐ Deceased		
Father's Mother	☐ Living ☐ Deceased		
Mother's Father	☐ Living ☐ Deceased		

Mother's Mother	☐ Living ☐ Deceased		
Sister	☐ Living ☐ Deceased		
Brother	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		
Other family member information:			

Social History

Immediate Family Members Living with Patient

Name	Gender	Age	Relationship to Patient

Education/ Employment:	Years of Education:			Degree(s):	
Currently Employed:	☐ Yes	☐ No	☐ Satisfied	☐ Unsatisfied	Been Fired: ☐ Yes ☐ No
☐ Never employed	☐ Student		☐ Problems with Employe		☐ Problems with co-workers
☐ Full-time	☐ Part-time		☐ Self-employed		☐ Temporary/seasonal
☐ Retired	☐ Disabled	Other:			

Tobacco Use: ☐ Yes ☐ No

If yes, how many packs a day:

Number of year:

Have you ever stopped? ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No

Drug of choice?

Ever used needles: ☐ Yes No

Alcohol Use: ☐ Yes ☐ No

If yes, how many drinks a day/week:

☐ Beer ☐ Wine ☐ Liquor

Have you been told you're drinking is a concern?

☐ Yes ☐ No

Notes:

Exercise: Do you exercise regularly? ☐ Yes ☐ No	What kind of exercise? Duration: Frequency:	
Sleep: How many hours, on average do you sleep a night? #hour:	Trouble falling asleep? ☐ Yes ☐ No	Trouble staying asleep? ☐ Yes ☐ No

Safety: Do you wear a seatbelt?	☐ Yes	☐ No		
Do you feel safe at home?	☐ Yes	☐ No		
Are you safe in your relationship?	☐ Yes	☐ No		
Do you have guns in your home?	☐ Yes	☐ No		
If so, do you lock the guns up?	☐ Yes	☐ No		
Sexuality: Are you sexually active?			☐ Yes	☐ No
If sexually active, do you practice safe sex?			☐ Yes	☐ No
Current sex partner(s) are:	☐ Male	☐ Female		
Birth control method:				
Have you ever had a sexually transmitted disease?			☐ Yes	☐ No
If so, please include info:				
Are you interested in being screened for sexually transmitted diseases?			☐ Yes	☐ No
Emotions: In the past year, have you had 2 or more weeks when you'd felt sad, depressed or lost interest in things you once enjoyed?			☐ Yes	☐ No
Have you felt depressed or sad much of the time in the past year?			☐ Yes	☐ No
Do you find yourself so anxious that you isolate or avoid situations?			☐ Yes	☐ No
Do you ever feel like hurting yourself or others?			☐ Yes	☐ No
Is there anything else you would like us to know about how you feel?				

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature _____ Printed Name _____ Date _____

HIPAA Consent Form

Patient Information:

Full Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I, the undersigned, hereby authorize and consent to the use and disclosure of my protected health information (PHI) as described in this form. This authorization is in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

- **Purpose of Disclosure:**

I understand that my PHI may be used or disclosed for the following purposes:

- Treatment: To provide, coordinate, or manage my healthcare and related services.
- Payment: To obtain payment for the healthcare services provided to me.
- Healthcare Operations: To carry out administrative, financial, and operational activities necessary for the practice.

- **Types of Information to be Disclosed:**

I authorize the use and disclosure of the following types of PHI:

- Medical records and test results
- Treatment and medication information
- Billing and insurance information

- **Recipients of Information:**

I authorize the disclosure of my PHI to the following individuals or entities:

- Healthcare providers involved in my treatment
- Insurance companies for payment purposes
- Business associates involved in healthcare operations

- **Duration of Consent:**

This consent shall remain in effect unless revoked by me in writing. I understand that revocation of consent will not affect any actions taken prior to the revocation.

- **Rights of Revocation:**

I understand that I have the right to revoke this consent at any time by providing a written revocation to the healthcare provider. However, I also understand that revocation will not apply to information already disclosed based on my prior consent.

I acknowledge that I have read and understood the contents of this consent form and that I have received a copy for my records.

Signature: _____

Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over 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's 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes [ ] No

If you are experiencing any of the problems on this form, 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?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

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Medical Records Release Form

Patient Information			
Name (First, Middle, Last):			DOB:
Address:	City:	State:	Zip:
Phone #:	Email:		

Records Request Details

Entity Releasing Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Entity Receiving Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Information Release Details			
Reason for Disclosure:			
Information to be Disclosed:			

Authorization

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial).

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Entity Receiving Records." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name Representative's Relationship to Patient

_____ _____
Witness (optional) Date