Clinical Screen

Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and circle the boxes that apply to you)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Felling down, depressed, or hopeless	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

Standard serving of one drink:
12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

Please circle your answer

How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Anxiety Screen

Over the last two weeks, how often have you been bothered by any of the following problems? (please circle your answer)

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

Audit-10

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

Standard serving of one drink:
12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

Please circle your answer

How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you…					
found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

been unable to remember what happened the night before you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year			Yes, during the last year
Has a relative, friend, doctor, or health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year			Yes, during the last year

The Columbia Scale (C-SSRS)

In the past month

Have you wished you were dead or wished you could go to sleep and not wake up?	Yes	No
Have you actually had any thoughts about killing yourself?	Yes	No
If you answered Yes to 2, answer 3,4,5, and 6. If you answered No to 2, go directly to question 6.		
Have you thought about how you might do this?	Yes	No
Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	Yes	No
Have you started to work out or worked out details of how to kill yourself?	Yes	No
Do you intend to carry out this plan?	Yes	No
In the past 3 months		
Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, given away valuables, wrote a will or suicide note, took put pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Yes	No
In your entire lifetime, how many times have you done any of these things?		

Depression Survey

Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and circle the boxes that apply to you)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
☐ Trouble falling or staying asleep or, ☐ Sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
☐ Poor appetite or, ☐ Overeating	0	1	2	3

	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
☐ Moving or speaking so slowly that other people could have noticed or, ☐ The opposite-being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3

PC-PTSD

In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:

Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Adult Member Information

Background

What brought you in for services today?		
Would you like an interpreter?	Yes	No
Do you have a developmental/intellectual disability?	Yes	No
If Yes, do you have an Individual Service Plan related to your developmental/intellectual disability?	Yes	No
Do you have an Emergency Crisis Plan? (if yes, please provide a copy)	Yes	No
Were you referred?	Yes	No
If yes, by whom were you referred?		
Nursing Facility Level of Care (NFLOC)?		

Height and Weight

Height (in inches)	
Weight (in pounds)	

Exam Dates

Date of last physical exam	_ _/_ _/_ _ _ _	Don't Know
Date of last dental exam	_ _/_ _/_ _ _ _	Don't Know
Date of last vision exam	_ _/_ _/_ _ _ _	Don't Know
Date of last hearing exam	_ _/_ _/_ _ _ _	Don't Know
Date of last bone density exam	_ _/_ _/_ _ _ _	Don't Know

Care Team				
Care Coordinator				
Name				
Primary Care Provider				
Name				
Phone Number (###-###-####)				
Behavioral Health Therapist				
Name				
Phone Number (###-###-####)				

Plan of Care				
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				

Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Self Management Goals				
Goal				

Intervention					
Progress					
Outcome					
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _	
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _	

Self Management Goals

Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _

Future Opportunities

Demographics/Psychosocial

Name of person filling out assessment				
Relationship of person filling out assessment to the person coming in today	**Self**	**Parent/ Guardian**	**Friend**	**Other**
If Other please describe				
Are there cultural or religious preferences that you would like your provider to be aware of today?		**Yes**	**No**	**Prefer not to answer**
If Yes please describe				

General Health Information						
Are you currently in any physical pain?					Yes	No
How much pain are you in today? Please enter best response, with 0 being no pain and 10 being the most pain you have ever had.						
Where is your pain?						
Have you ever had a traumatic brain injury (head injury, concussion)?					Yes	No
Do you need help with transportation to appointments?					Yes	No
In general, would you say your physical health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
In general, would you say your mental health is:	Excellent	Very Good	Good	Fair	Poor	Prefer not to answer
Have you had any psychiatric hospitalization in the last 6 months?				Yes	No	Prefer not to answer
Are you currently taking atypical psychotropic medications, such as Ability, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?				Yes	No	Prefer not to answer
How much are you bothered by medication side effects (for example, shaking and trembling, not being able to think clearly, gaining or losing weight, or sexual problems)?		Not bothered at all	Bothered a little	Bothered moderately	Bothered a lot	Prefer not to answer

Diagnosis
Diagnosis

Member Goals
Member Goals

Home Life		
How may people live in your home, including you?		
Who lives in your home with you? (circle all that apply)		
Mother	Stepmother	Father
Stepfather	Two Mothers	Two Fathers
Mother's boyfriend	Father's girlfriend	Boyfriend/partner
Girlfriend/partner	Spouse/Partner's Mother or Father	Grandmother(s)
Grandfather(s)	Aunt(s)	Uncle(s)
Cousin(s)	Foster Parent(s)	Friend(s)
Other Relative(s)	Pet(s)	None of these apply

What is your current living arrangement? (circle one)	
Homeless	Dependent Living
Dependent Living: Residential Care	Dependent Living: Foster Care/Foster Home
Dependent Living: Crisis Residence	Dependent Living: Institutional Setting
Dependent Living: Jail/Correctional Facility/Other Institutions Under the Justice System	Dependent Living: Private Residence

Independent Living				Unknown	Private Residence, Living Arrangement not Specified			
Have you been homeless at any time in the last 6 months?						Yes	No	Prefer not to answer
Are you having any problems at home? (circle all that apply)								
Violence			Money			Fighting		
House			Food			Gas		
Electricity			Water			Cooling		
You are out of work			Spouse/Partner out of work			Substance use of others		
Concerns with a family member			Do not have any of these problems					
Would you like to discuss this with someone?						Yes	No	Prefer not to answer
Current Providers								
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Name			Phone (###-###-####)			Do you want them to be part of your Care Team?		
							Yes	No
Resources								
Community Resources and Services Being Utilized								
Resource					**Service (circle all that apply)**			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services			Protective Services			Juvenile Justice Services		
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)			Emergency Food			Other		
Section 8 Housing								
Section 8 Housing								

Needed Community Resources and Services								
Resource					Service (circle all that apply)			
Income Support Division								
Medicaid	CHIP	SNAP	TEFAP	TANF	GA	RRS	LIHEAP	CSBG
Behavioral Health Services Division (BHSD)								
Mental Illness Treatment					Substance Abuse Treatment			
Aging and Long Term Services Department (ALTSD)								
Consumer and Elder Rights Division (CERD) Assistance					Aging Network Division (AND) Assistance			
Child Support Enforcement Services (CSES)								
Paternity Establishment					Collection/Enforcement			
Children Youth and Families (CYFD)								
Early Childhood Services		Protective Services			Juvenile Justice Services			
Department of Health (DOH)								
Immunizations					WIC			
Religious Organization								
Emergency Housing (Short Term/Transitional)		Emergency Food			Other			
Section 8 Housing								
Section 8 Housing								

Disaster Plan

Disaster Preparedness Plan

Adult Health & Well-Being

Health Behaviors

In the past three months have you smoked cigarettes or used any form of tobacco (e.g. chew, dip, cigars, hookah and/or e-cigarettes)?		Yes	No
Have you ever ridden in a car driven by someone (including yourself) that was high or was using alcohol or drugs?		Yes	No
Does anyone in your home take opioids for an ongoing medical condition ? (OxyContin, Hydrocodone, Codeine)		Yes	No
Do you lock your opioid medications in a medicine cabinet or other locked location?		Yes	No
Do you have a smoke detector in your home?		Yes	No
Do you have gas heating or appliances in your home?		Yes	No
Do you have carbon monoxide detector in your home?		Yes	No

Caregiver

Do you have a caregiver that comes into the home, because of a health care problem, to provide you with assistance?		Yes	No
Is caregiver a relative, friend or from an agency?	Relative	Friend	Agency
Caregive/Agency Name			
Caregive/Agency phone number (###-###-####)			

Caregive/Agency Specialty				
How many hours per day/week does caregiver come into your home? (☐ per day, or ☐per week)				
What items does your caregiver help with?				
Do you need more help than you are receiving?			Yes	No
Please explain:				

ADL/IADL				
Please indicate your ability to do the activities in the table below. If you are Receiving Help for any of these, indicate Yes or No,				
Bathing				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Dressing				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Grooming				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Mouth care				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Toileting				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Transferring bed/chair				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Walking				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Climbing Stairs				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Eating				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Shopping				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Cooking				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	

Manging medications				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Using phone book/ looking up numbers				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Doing housework				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Doing laundry				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Driving or using public transportation				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	
Managing finances				Receiving Help?
Independent	Need Help	Dependent	Cannot Do	

Sleep

On average how many hours of sleep do you get in a 24 hour period		
Do you feel your sleep is restful?	Yes	No

Employment

What is your current type of employment?		
Employed-Full time	Employed-Part time	Not employed, but seeking employment
Not employed, not seeking employment	Not in labor force (e.g. retired, disabled, homemaker, student, volunteer	Prefer not to answer
If not employed (circle all that apply):		
I am in the the process of seeking benefits or I don't want to risk losing my benefits	I worry that my symptoms will interfere with my work	I'm not sure how to go about getting a job
Not applicable	Other	Prefer not to answer
If employed, how many hours do you work per week		

Durable Medical Equipment

Item				
Air-fluidized beds and other support surfaces	Have	Want	Wish to discuss	Don't Need
Bar in toilet/shower	Have	Want	Wish to discuss	Don't Need
Blood sugar (glucose) test strips	Have	Want	Wish to discuss	Don't Need
Blood sugar monitors	Have	Want	Wish to discuss	Don't Need
Canes (however, white canes for the blind aren't covered)	Have	Want	Wish to discuss	Don't Need

Commode chairs	Have	Want	Wish to discuss	Don't Need
Continuous passive motion (CPM) machine	Have	Want	Wish to discuss	Don't Need
Crutches	Have	Want	Wish to discuss	Don't Need
Eyeglasses/contacts	Have	Want	Wish to discuss	Don't Need
Hearing aid or other hearing equipment	Have	Want	Wish to discuss	Don't Need
Hospital beds	Have	Want	Wish to discuss	Don't Need
Infusion pumps and supplies (when necessary to administer certain drugs)	Have	Want	Wish to discuss	Don't Need
Manual wheelchairs and power mobility devices	Have	Want	Wish to discuss	Don't Need
Nebulizers and nebulizer medications	Have	Want	Wish to discuss	Don't Need
Oxygen equipment and accessories	Have	Want	Wish to discuss	Don't Need
Patient lifts	Have	Want	Wish to discuss	Don't Need
Shower bench	Have	Want	Wish to discuss	Don't Need
Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories	Have	Want	Wish to discuss	Don't Need
Suction pumps	Have	Want	Wish to discuss	Don't Need
Traction equipment	Have	Want	Wish to discuss	Don't Need
Translation devices	Have	Want	Wish to discuss	Don't Need
Walkers	Have	Want	Wish to discuss	Don't Need
Wheelchair	Have	Want	Wish to discuss	Don't Need
Do you have other adaptive equipment that is not listed above?			Yes	No
If yes, please describe:				
Do you want other adaptive equipment that is not listed above?			Yes	No
If yes, please describe:				

Legal					
Do you have an advance directive and/or living will?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Do you have a psychiatric advance directive?			Yes	No	Don't Know
Do you have a copy of your advance directive and/or living will to put in your record?				Yes	No
Have you given Power of Attorney (POA) to someone?				Yes	No
If yes, who?					
Do you have a copy of your POA to put in your record?				Yes	No
In the past six months, have you been arrested?	Yes	No	Don't know	Prefer not to answer	Not applicable
In the past six months, were you the victim of any violent crimes, such as assault, rape,	Yes	No	Don't know	Prefer not to answer	Not applicable

Safety/Injuries		
Do you have a gun/firearm in the home?	Yes	No
If yes, is it unloaded?	Yes	No
If yes, is it locked up?	Yes	No
During the past 12 months did you smoke any marijuana or hashish?	Yes	No
During the past 12 months did you use anything else to get high (includes illegal drugs, over-the-counter and prescription drugs, and things you sniff or huff?	Yes	No
Please answer the following if you answered yes to either of the last two questions above. Otherwise, leave the following blank.		
Do you use drugs to relax, feel better about yourself or fit in?	Yes	No
Do you ever use drugs while you're by yourself, alone?	Yes	No
Have you ever gotten into trouble while you were using drugs?	Yes	No
Do you ever forget things you did while using drugs?	Yes	No
Does your family or friends ever tell you that you should cut down on your drug use?	Yes	No

Client Concerns
What are your future plans for work, career and family goals?

Financial Support		
In the past six months, did you generally have enough money each month to cover food?	Yes	No
In the past six months, did you generally have enough money each month to cover clothing?	Yes	No
In the past six months, did you generally have enough money each month to cover housing?	Yes	No

In the past six months, did you generally have enough money each month to cover traveling around to get things, shopping, medical appointments, or visiting friends or relatives?	Yes	No
In the past six months, did you generally have enough money each month to cover social activities like movies or eating in restaurants?	Yes	No
In the past six months, did you generally have enough money each month to cover Heating, air conditioning, water, electricity, gas?	Yes	No
Have you received mental health or developmental disability services?	Yes	No
Do you have questions you would like to discuss with your provider?	Yes	No
Do you know what benefits are available to you?	Yes	No
Do you feel your benefits meet your needs?	Yes	No

Clinical Summary

Allergies

Medication allergies	Yes	No
If yes, what are they?		
Food allergies	Yes	No
If yes, what are they?		
Environmental allergies (hay fever, dust, etc.)	Yes	No
If yes, what are they?		
Pharmacy Name		
Pharmacy Location		
Pharmacy phone number (###-###-####)		

Current Medications

Medication	Dose (if known)	How often do you take them?	Start Date	What are they for?

Previous medications: Only list atypical anti-psychotics from the following: Risperdal (Risperidone), Seroquel (Quetiapine), Geodon (Ziprasidone), Zyprexa (Olanzapine), Invega (Paliperidone), Saphiris (Asenipine), Clozaril (Clozapine), Abilify (Aripiprazole), Latuda (Lurasidone), Vraylar (Cariprazine), Rexulti (brexpiprazole)					
Medication	Dose (if known)	How often do you take them?	Start Date	End Date	What are they for?
Now or in the past 6 months, have you taken any prescribed medications for emotional or behavioral symptoms?				Yes	No
Have the medications helped you feel better?				Yes	No
In what ways have they helped?					
In the past 6 months have you had any bad side effects from these medications?				Yes	No
What were the bad side effects?					

Over the counter medications, herbs, vitamins, or supplements:				
Medication, herb, vitamin, or supplement	Dose (if known)	How often do you take them?	Start Date	What are they for?
Do you have trouble taking medications as prescribed?	Do not have to take medicine	Always as prescribed	Sometimes as prescribed	Seldom as prescribed
Do you want help with this?			Yes	No
Other treatments that you are receiving (counseling, psychotherapy, OT, PT, chiropractor, acupuncture, traditional healing, other):				

Health History							
Condition/Behavior			If present, how much are you bothered by this condition/ behavior?			Would you like to talk about his with your provider?	
Do you have or have you ever had: (circle Past and Present if ongoing)							
ADHD	Past	Present	Yes	A little	No	Yes	No
AIDS/HIV	Past	Present	Yes	A little	No	Yes	No
Alcohol abuse	Past	Present	Yes	A little	No	Yes	No
Anxiety	Past	Present	Yes	A little	No	Yes	No
Any heart problems or heart murmur	Past	Present	Yes	A little	No	Yes	No
Any other significant problems	Past	Present	Yes	A little	No	Yes	No
Any primary current skin problem (acne, eczema)	Past	Present	Yes	A little	No	Yes	No
Appendicitis	Past	Present	Yes	A little	No	Yes	No
Anemia or bleeding problem	Past	Present	Yes	A little	No	Yes	No
Arthritis	Past	Present	Yes	A little	No	Yes	No
Asthma, bronchitis, bronchiolitis, pneumonia	Past	Present	Yes	A little	No	Yes	No
Autism	Past	Present	Yes	A little	No	Yes	No
Bedwetting	Past	Present	Yes	A little	No	Yes	No
Bipolar disorder	Past	Present	Yes	A little	No	Yes	No
Bladder or kidney infection	Past	Present	Yes	A little	No	Yes	No
Blood transfusion	Past	Present	Yes	A little	No	Yes	No
Cancer	Past	Present	Yes	A little	No	Yes	No
Carpal tunnel	Past	Present	Yes	A little	No	Yes	No
Cataracts	Past	Present	Yes	A little	No	Yes	No
Chickenpox	Past	Present	Yes	A little	No	Yes	No
Constipation requiring doctor visits	Past	Present	Yes	A little	No	Yes	No
Convulsions or neurological problems	Past	Present	Yes	A little	No	Yes	No
Depression	Past	Present	Yes	A little	No	Yes	No
Developmental/ Intellectual Disability	Past	Present	Yes	A little	No	Yes	No
Diabetes	Past	Present	Yes	A little	No	Yes	No
Dizziness	Past	Present	Yes	A little	No	Yes	No
Drug abuse	Past	Present	Yes	A little	No	Yes	No

Eating disorder	Past	Present	Yes	A little	No	Yes	No
Fainting	Past	Present	Yes	A little	No	Yes	No
Frequent abdominal pain	Past	Present	Yes	A little	No	Yes	No
Frequent ear infections	Past	Present	Yes	A little	No	Yes	No
Frequent headaches	Past	Present	Yes	A little	No	Yes	No
Gallbladder disease	Past	Present	Yes	A little	No	Yes	No
Glaucoma	Past	Present	Yes	A little	No	Yes	No
Gout	Past	Present	Yes	A little	No	Yes	No
Hallucinations	Past	Present	Yes	A little	No	Yes	No
Headache	Past	Present	Yes	A little	No	Yes	No
Hearing problems	Past	Present	Yes	A little	No	Yes	No
Hepatitis (A, B, C)	Past	Present	Yes	A little	No	Yes	No
Hernia	Past	Present	Yes	A little	No	Yes	No
Herpes	Past	Present	Yes	A little	No	Yes	No
High blood pressure (hypertension)	Past	Present	Yes	A little	No	Yes	No
Kidney disease	Past	Present	Yes	A little	No	Yes	No
Liver disease	Past	Present	Yes	A little	No	Yes	No
Low blood pressure (hypotension)	Past	Present	Yes	A little	No	Yes	No
Lung disease	Past	Present	Yes	A little	No	Yes	No
Measles	Past	Present	Yes	A little	No	Yes	No
Mumps	Past	Present	Yes	A little	No	Yes	No
Mental illness	Past	Present	Yes	A little	No	Yes	No
Mental retardation	Past	Present	Yes	A little	No	Yes	No
Nasal allergies	Past	Present	Yes	A little	No	Yes	No
Neurological disorder	Past	Present	Yes	A little	No	Yes	No
Obesity or been Overweight	Past	Present	Yes	A little	No	Yes	No
Pacemaker	Past	Present	Yes	A little	No	Yes	No
Physical abuse	Past	Present	Yes	A little	No	Yes	No
Pneumonia	Past	Present	Yes	A little	No	Yes	No
Polio	Past	Present	Yes	A little	No	Yes	No
Problems with eyes or vision	Past	Present	Yes	A little	No	Yes	No
Legal blindness	Past	Present	Yes	A little	No	Yes	No
Problems with ears or hearing	Past	Present	Yes	A little	No	Yes	No
Rheumatic fever	Past	Present	Yes	A little	No	Yes	No
Sexual abuse	Past	Present	Yes	A little	No	Yes	No
Sexually transmitted disease	Past	Present	Yes	A little	No	Yes	No

Shingles	Past	Present	Yes	A little	No	Yes	No
Sleep problems	Past	Present	Yes	A little	No	Yes	No
Stomach problems	Past	Present	Yes	A little	No	Yes	No
Stroke	Past	Present	Yes	A little	No	Yes	No
Suicide attempt	Past	Present	Yes	A little	No	Yes	No
Thyroid or other endocrine problems	Past	Present	Yes	A little	No	Yes	No
Tobacco use	Past	Present	Yes	A little	No	Yes	No
Tuberculosis	Past	Present	Yes	A little	No	Yes	No
Ulcers	Past	Present	Yes	A little	No	Yes	No
Urinary problems/incontinence/wetting self	Past	Present	Yes	A little	No	Yes	No
Use of alcohol or drugs	Past	Present	Yes	A little	No	Yes	No
Violent or aggressive behaviors	Past	Present	Yes	A little	No	Yes	No
Wandering or running away	Past	Present	Yes	A little	No	Yes	No

Condition/Behavior-Do you have or have you ever had: (circle Past and Present if ongoing)		
Problems with teeth	Yes	No
Problems with gums	Yes	No
Difficulty chewing	Yes	No
Difficulty swallowing	Yes	No
Appetite change last six months	Yes	No
Weight loss	Yes	No
Weight gain	Yes	No

Women's Health	
Period started at age	
Number of pregnancies	
Number of live births	
Number of miscarriages	

Do you have or have you ever had:			
Birth Control		Yes	No
If yes, which one			
Hysterectomy		Yes	No
PAP		Yes	No
If yes, indicated date of your PAP	_ _/_ _/_ _ _ _	Don't know	
Mammogram		Yes	No
If yes, indicated date of mammogram	_ _/_ _/_ _ _ _	Don't know	

Men's Health			
Penis discharge		Yes	No
Sore on penis		Yes	No
Erectile dysfunction		Yes	No
Testicular lump		Yes	No
Vasectomy		Yes	No
PSA	_ _/_ _/_ _ _ _	Yes	No
Prostrate problems		Yes	No
Prostate exam	_ _/_ _/_ _ _ _	Yes	No

E.R. Visits

Date	Reason

Surgeries

Date	Reason

Substance Abuse Treatments

Date	Reason

Sexual Activity

Are you using a method to prevent pregnancy?	Yes	No
If so, which types (condoms, pills, Depo shot, patch, Nexplanon/Implanon, foam, sponge, withdrawal, ring, IUD etc.)?		

Immunizations

Up to date?	Yes	No	Don't know/ Not Sure	Refused
During the past 12 months have you had either a flu shot or a flu vaccine that was sprayed into your nose?	Yes	No	Don't know/ Not Sure	Refused
A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime, and is different from the flu shot. Have you ever had a pneumonia shot?	Yes	No	Don't know/ Not Sure	Refused

Have you ever had the shingles or zoster vaccine?	Yes	No	Don't know/ Not Sure	Refused
Please indicate any of the following immunizations you have received:				
Chicken Pox	Yes	No	Don't know/ Not Sure	Within last 10 years
DTaP (diptheria, tetanus, acellular pertussis; 5 doses at 2, 4 6, 15 -18 mo & 4-6 yrs; <7 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Influenza (annual dose beginning at 6 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis A (2 doses; and 18-23 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hepatitis B (3 doses, birth, 1 to 2 mo & 6 to 18 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Hib (Haemophilus influenzae type b; 4 doses at 2, 4, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
HPV (Human Papilloma Virus; ages 11 to 26 females; ages 11 to 21 males)	Yes	No	Don't know/ Not Sure	Within last 10 years
IPV (Inactivated poliovirus; 4 doses ; 2, 4, 6 -18 mos & 4-6 yrs; <18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
MMR (measles, mumps rubella; 2 doses 12-15 mos & 4-6 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
Meningococcal (2 doses; 11-12 yrs and booster 16-18 yrs)	Yes	No	Don't know/ Not Sure	Within last 10 years
PCV13 (Pneumococcal conjugate; 4 doses at 2, 4, 6, 12 or 15 mos)	Yes	No	Don't know/ Not Sure	Within last 10 years
Shingles	Yes	No	Don't know/ Not Sure	Within last 10 years
Td/Tdap (Tetanus, diphtheria, pertussis; 11 to 12 yrs; 10 yr boosters)	Yes	No	Don't know/ Not Sure	Within last 10 years

Hospitalizations	
Date	**Reason**

Health Concerns		
Specific Health Concerns - I would like to talk with or get help from my healthcare provider		
Accident or injury prevention	Yes	No
Ear, eye or mouth care	Yes	No
Exercise and nutrition	Yes	No
Health screening tests	Yes	No
Money, housing case management	Yes	No
Living will, end-of-life issues	Yes	No
Long term care needs	Yes	No
Family or personal problems	Yes	No
Depression or other mental concerns	Yes	No
Preventing cancer	Yes	No
Preventing heart disease	Yes	No
Problems with my healthcare	Yes	No
Other	Yes	No