



# FAMILY HEALTH & WELLNESS CENTER

1500 E Cedar Ave., Ste 26, Flagstaff, Arizona 86004

## PATIENT INFORMATION SHEET

Name(Last, First, Middle):		Other Names Used(Alias):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Chart #:	
Date of Birth:	Place of Birth(City & State):	Social Security #:	Primary Language:	Secondary Language:	
Mailing Address:		City/State:	Zip Code:	Primary Phone #:	
Current Community:		Date Moved:	Secondary Phone #:		
<b>Marital Status:</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		<b>Ethnicity:</b> <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER: _____	<b>Primary Tribal Enrollment:</b>  <b>Other Tribe(s):</b>	<b>Degree:</b>  <b>Degree:</b>	<b>Census Number:</b>  <b>Religious Preference:</b>
<b>Employer Information:</b> <input type="checkbox"/> EMPLOYED(FULL-TIME) <input type="checkbox"/> DISABLED <input type="checkbox"/> EMPLOYED(PART-TIME) <input type="checkbox"/> STUDENT <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> CHILD UNDER 4 <input type="checkbox"/> RETIRED		<b>Patient's Employer:</b> <b>Employer Address:</b> <b>Phone #:</b>			
		<b>Spouse's Employer:</b> <b>Employer Address:</b> <b>Phone #:</b>			
<b>Preferred Contact Method:</b> <input type="checkbox"/> PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL <input type="checkbox"/> NONE		<b>Internet Access:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Where:</b>	<b>Email Address:</b>	
Are you related to a NACA Employee? Please list Name & Dept. :					

## PARENTAL INFORMATION for MINORS

Fathers Name:	Father's Employer:	Contact Phone #:	Place of Birth: (City/State)
Mother's Maiden Name:	Mother's Employer:	Contact Phone #:	Place of Birth: (City/State)

## HEALTH INSURANCE INFORMATION

Medicare Number:	Suffix:(A,B & D):	Part A Eligibility Date:	Part B Eligibility Date:
AHCCCS ID #:		Plan Name:	Eligibility Date:
Private Insurance Company Name:		Policy ID#:	Insurance Phone #:
Policyholder's Name:	Policyholder's Date of Birth:	Group #:	Effective Date:

## EMERGENCY CONTACT AND NEXT OF KIN INFORMATION

Name of Emergency Contact:	Phone # of Emergency Contact:	Relationship to Patient:
Emergency Contact's Address:		Zip Code:
City/State:		
Name of Next-of-Kin Contact	Phone # of Next-of-Kin Contact:	Relationship to Patient:

## MILITARY SERVICE INFORMATION

Military Service:	Vietnam Veteran:	Branch:	Entry Date:	Separation Date:	Service Connected:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

\* I certify that the information on this form is true and accurate, as of the date of signature.

\* I agree to contact NACA if the information on this form changes in any way.

\* I hereby authorize NACA to furnish information to insurance carriers concerning my illness, and I hereby irrevocably assign to NACA payments for medical services rendered.

\* I understand that I am financially responsible for ALL charges whether or not covered by insurance.

**Patient Signature**

**Date**



**NACA**  
Native Americans For Community Action, Inc.

**GENERAL CONSENT FOR TREATMENT**

Patient/Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**General Consent for Treatment**

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology, and laboratory procedures and medication prescription and administration.

I understand no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure, unless there is an emergency or extraordinary circumstance. Informed consent means the provider will disclose to me expected benefits and risks of a particular procedure and/or treatment. This understanding includes research and/or experimental procedures will not be performed without my knowledge and consent.

**Release of Medical Information**

I authorize *Native Americans for Community Action, Inc.* (NACA) to use my health information related to the services provided for the following purposes: my treatment, obtaining payment for the services provided, and for health care operations of NACA or other treating providers, as permitted under federal and state laws and regulations.

**Payment**

I assign and authorize payment for all services provided directly to NACA from my insurance company or third party payer, including, but not limited to, Medicare, AHCCCS, commercial health insurance, automobile no-fault insurance, and workers compensation insurance.

In consideration of the health care services provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, and non-covered services.

**I have read this consent form, or it has been read to me, and I understand the contents. My questions have been answered to my satisfaction.**

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (if applicable)

\_\_\_\_\_  
Relationship to Patient/Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



# NACA

Native Americans For Community Action, Inc.

## ACKNOWLEDGEMENT OF INFORMATION RECEIVED

Patient/Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I confirm I have received the following information in writing, and understand its content. I understand it is my responsibility to address any further questions I have regarding this information with my medical practitioner, case manager, nurse, therapist, and/or counselor.

\_\_\_\_\_ I have received a copy of the **Patient/Client Rights and Responsibilities**, including the grievance  
Initial procedure and mandatory reporting requirements.

\_\_\_\_\_ I have received a copy of the **HIPAA Notice of Privacy Practices**, including who to contact if I  
Initial suspect my protected health information has been compromised.

\_\_\_\_\_ I have received information regarding **Advance Directives** and my options for establishing advance  
Initial directives and/or a power of attorney.

\_\_\_\_\_ I have received a copy of the **Fee Schedule** and understand I am responsible for payment for services  
Initial received. I agree to cancel appointments at least 24 hours in advance or agree to pay a \$25  
cancellation fee.

\_\_\_\_\_ I have received notification of **Retention of Health Records** policy and understand it is my  
Initial responsibility to obtain copies of my health record.

\_\_\_\_\_ **For the DUI program only:** I have received written information regarding:

- Initial
- The procedures for conducting a DUI screening;
  - The timeline for initiating and completing a DUI screening; and
  - The consequences of not complying with the procedures and the timeline.

\_\_\_\_\_  
Patient/Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee/Witness signature

\_\_\_\_\_  
Date

## NACA Family Health Center

CHART # \_\_\_\_\_

DATE: \_\_\_\_\_

### Patient Health Questionnaire (PHQ-9)

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In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your provider. Thank you for taking an active part in your health care.

If the health screenings are positive, would you like to be contacted by the Behavioral Health Department?

Yes

No

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "X" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly Every Day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself-- or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thinking that you would be better off dead or that you want to hurt yourself.	0	1	2	3
ADD COLUMNS				
(Healthcare Professional: For Interpretation of TOTAL, refer to accompanying score card)				<b>TOTAL =</b> <input style="width: 50px;" type="text"/>

10. 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?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____
--	---

Score/ Chart Action:	0-14 Chart Only	Greater than 15: BH Referral and Chart
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<b>Tobacco Use Screening</b>	
TOBACCO USE: CURRENT USE? YES \ NO	EVER? YES \ NO # PACKS _____ YEARS _____
DO YOU WANT TO QUIT? YES \ NO	WOULD YOU LIKE ASSISTANCE TO QUIT? YES \ NO
Clinic Referral and Chart	BH Referral and Chart

Provider initials and Date: \_\_\_\_\_

PLEASE RETURN THE COMPLETED FORM TO YOUR PROVIDER

**(OVER)**

# NACA Family Health Center

CHART # \_\_\_\_\_

DATE: \_\_\_\_\_

## CAGE Questionnaire: Screening test for Alcohol Dependence

Please check the one response to each item that best describes how you have felt and behaved over your whole life.

Do you currently drink alcohol, beer or wine?  Yes  No \*Please proceed to intimate Partner/domestic Violence Screening.

1. Have you ever felt you should cut down on your drinking?

Yes  No

2. Have people annoyed you by criticizing your drinking?

Yes  No

3. Have you ever felt bad or guilty about your drinking?

Yes  No

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang-over (eye-opener)?

Yes  No

### Healthcare Provider Use Only:

Check one	Results	Health Factor	Chart:
	Answers No to all four questions	CAGE 0/4	
	Answers YES to one of the four questions	CAGE 1/4	Need for further clinical investigation including questions on amount and frequency, etc.
	Answers YES to two of the four questions	CAGE 2/4	Need for further clinical investigation and/or referral as indicated by clinician's expertise
	Answers YES to three of the four questions	CAGE 3/4	Evaluate, treat and/or referral as indicated by clinician's expertise
	Answers YES to all four questions	CAGE 4/4	Evaluate, treat and/or referral as indicated by clinician's expertise

### Intimate Partner/Domestic Violence Screening:

1. Are you in a relationship with a person who physically hurts or threatens you?

Yes  No

2. Have you ever been in a relationship with a person who hurt you?

Yes  No

3. Would you like to talk to someone about Intimate Partner/Domestic Violence?

Yes  No

### Healthcare Provider Use Only:

Check one	Results	Health Factor
	Negative	Denies being a current or past victim of IPV/DV
	Past	Denies being a current victim, but discloses being a past victim of IPV/DV
	Present	Discloses current IPV/DV (document health and safety assessment)
	Present & Past	Discloses past and current IPV/DV (document health and safety assessment)
	Unable to screen	Chart
	Refused	Patient Declined exam or screening.

Provider initials and Date: \_\_\_\_\_

PLEASE RETURN THE COMPLETED FORM TO YOUR PROVIDER

## Medical History - Adult

*All information is kept strictly confidential*

Name	Birth date/Age	M	F	Today's Date
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1. What is the main reason for your visit today? \_\_\_\_\_

2. Are there any other things you would like to discuss with the doctor today if there is time?

\_\_\_\_\_

3. Please list all your current medications and the reason for using each:

Medication	Reason	Medication	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Are you allergic to any medications; if YES please indicate which one(s) and what reaction occurred?

\_\_\_\_\_

### Family History

1. Please indicate if any of the following have occurred in members of your family (blood relatives including parents, grandparents, brothers, sisters, or children):

YES	NO		YES	NO	
_____	_____	Diabetes	_____	_____	High blood pressure
_____	_____	Breast cancer	_____	_____	Migraine
_____	_____	Colon or rectal cancer	_____	_____	Alcoholism
_____	_____	Stroke	_____	_____	Mental illness or suicide
_____	_____	Heart attack or bypass surgery			
_____	_____	Allergic disease (asthma, hay fever, eczema)			

2. Are there any other conditions that run in your family? \_\_\_\_\_

3. If any of the following are deceased, please indicate age at death and cause of death.

Relative	Age Died	Cause	Relative	Age Died	Cause
Father	_____	_____	Mother	_____	_____
Father's father	_____	_____	Mother's father	_____	_____
Father's mother	_____	_____	Mother's mother	_____	_____
Brother	_____	_____	Sister	_____	_____
Brother	_____	_____	Sister	_____	_____

### Medical History

1. Please list any surgical operations you have had (by name or organ involved), and indicate your age at the time, or the year you had the operation:

Operation	Age/Year	Operation	Age/Year
_____	_____	_____	_____
_____	_____	_____	_____

2. Please list any **major illnesses or injuries** you have had (other than those requiring surgery listed above), and indicate the age or the year they occurred:

Illnesses or Injury	Age/ Year	Illnesses or Injury	Age/Year
_____	_____	_____	_____
_____	_____	_____	_____

3. How many children do you have? \_\_\_\_\_

4. What measures, if any, are you or your partner using to prevent pregnancy and sexually transmitted diseases (STD)? \_\_\_\_\_

5. If female, how many times have you been pregnant? \_\_\_\_\_

6. Are you now pregnant or trying to become pregnant?  YES  NO

7. Do you smoke or chew tobacco?  NO  YES, how often? \_\_\_\_\_

8. How much alcohol do you drink? \_\_\_\_\_

9. Do you use marijuana, cocaine, ecstasy, or other drugs?  YES  NO

### Medical Problems- Present & Past

1. Please indicate if you have **ever** had any of the following:

- | YES   | NO    |                                    |
|-------|-------|------------------------------------|
| _____ | _____ | Asthma                             |
| _____ | _____ | Diabetes                           |
| _____ | _____ | Blood transfusion                  |
| _____ | _____ | Reactive TB skin test              |
| _____ | _____ | High blood pressure                |
| _____ | _____ | Breast lump                        |
| _____ | _____ | Abnormal pap smear                 |
| _____ | _____ | Menopause                          |
| _____ | _____ | Vomited or passed blood            |
| _____ | _____ | Jaundice or hepatitis              |
| _____ | _____ | Bladder or kidney infection        |
| _____ | _____ | Phlebitis (blood clot)             |
| _____ | _____ | Convulsions                        |
| _____ | _____ | Nervous breakdown or been suicidal |

2. Please indicate if you **currently** have any of the following:

- | YES   | NO    |                                     |
|-------|-------|-------------------------------------|
| _____ | _____ | Skin Problems                       |
| _____ | _____ | Allergies or "sinus"                |
| _____ | _____ | Headaches (frequent or severe)      |
| _____ | _____ | Dizziness                           |
| _____ | _____ | Trouble Hearing                     |
| _____ | _____ | Other ear trouble                   |
| _____ | _____ | Sores that won't heal               |
| _____ | _____ | Persistent cough                    |
| _____ | _____ | Frequent chest colds                |
| _____ | _____ | Frequent abdominal pain             |
| _____ | _____ | Frequent constipation               |
| _____ | _____ | Frequent diarrhea                   |
| _____ | _____ | Weak urine stream                   |
| _____ | _____ | Frequent loss of urine              |
| _____ | _____ | Trouble with menstrual periods      |
| _____ | _____ | Frequent vaginal infection          |
| _____ | _____ | Stiff or painful joints             |
| _____ | _____ | Back or neck trouble                |
| _____ | _____ | Trouble sleeping                    |
| _____ | _____ | Frequent depression                 |
| _____ | _____ | Frequent anxiety                    |
| _____ | _____ | Severe premenstrual symptoms        |
| _____ | _____ | Unusual tiredness or lack of energy |