Aunt Martha's Health Center
Patient Registration Form – ADULT

NextGen Record # _____

PATIENT INFORMATION

Today's Date	Last Name	First Name	Middle

Date of Birth	Age	Gender: ❑ Female ❑ Male

Address	City	State	Zip Code

Primary Language:
❑ English ❑ Spanish ❑ Other: _____

Do you have Advance Directives for Health Care? (i.e., Living Will or Power of Attorney)
❑ YES ❑ NO ❑ Not Sure

Social Security Number:
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Marital Status:
❑ Divorced ❑ Legally Separated ❑ Life Partner
❑ Married ❑ Single ❑ Unknown
❑ Widowed

Home Phone Number: (____) _____
May we leave a message at your home phone number? ❑ Yes ❑ No

Daytime Phone Number: (____) _____
May we leave a message at your daytime phone number? ❑ Yes ❑ No

Alternate Phone Number: (____) _____
May we leave a message at your alternate phone number? ❑ Yes ❑ No

Contact Preference:
❑ Home Phone
❑ Daytime Phone
❑ Alternate Phone
❑ No Phone Contact

If the patient is in 8th grade or under, please indicate School District # and School Name. If not, indicate N/A.
❑ 8th grade and under ❑ N/A

School District # _____ School Name: _____

Is the patient enrolled in Illinois Health Connect? ❑ No ❑ Yes ❑ Unsure (Need clarity from Registration Staff)

SPECIAL NEEDS / ADDITIONAL DEMOGRAPHIC INFORMATION

Do you have any of the following impairments?
Sight ❑ No ❑ Yes
Sound ❑ No ❑ Yes
Verbal ❑ No ❑ Yes
Recent Trauma ❑ No ❑ Yes

Educational Mechanism
Verbal instructions given
Written instructions given

Special Religious Concerns
❑ No ❑ Yes
If yes, please explain:
_____

Homeless Status: ❑ Not Homeless ❑ Shelter ❑ Transitional ❑ Doubling Up ❑ Street ❑ Unknown

Migrant Worker Status: ❑ Not a farm worker ❑ Seasonal ❑ Migrant

Language Barrier: ❑ No ❑ Yes

Veteran Status: ❑ No ❑ Yes

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White

Ethnicity: ❑ Latino/Hispanic ❑ Non Hispanic ❑ Unknown Ethnicity

How did you hear about our services? (check all that apply)
❑ Flyer ❑ Sign ❑ Radio ❑ T.V. ❑ School ❑ Health Fair ❑ Billboards
❑ Mailing ❑ Church ❑ Presentation ❑ Phone Book ❑ Family/Friend ❑ Internet/Website
❑ Current Patient ❑ Dr. _____ ❑ Insurance Plan _____
❑ Hospital _____ ❑ Social Services Agency _____
❑ Aunt Martha's Employee _____

EMERGENCY CONTACT

Emergency Contact Name | Phone Number ( ) | Relationship

RESPONSIBLE PARTY

Parent/Legal Guardian/Responsible Party: **IF SAME AS PATIENT, please check box** ❑

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Last Name | First Name | Middle | Previous Last Name

Date of Birth ____/____/____ Age _____ Relationship to Pt. _____ Gender: ❑Male ❑Female

Address | City | State | Zip Code | County

(_____) Primary Phone Number | (_____) Alternate Phone Number

INSURANCE INFORMATION

Please show your insurance card and picture identification to the receptionist. Income verification is required for all patients, regardless of insurance status.

Person Responsible for Bill: **IF SAME AS PATIENT, please check box** ❑

Is this person a patient here? ❑ No ❑ Yes Is this person covered by insurance? ❑ No ❑ Yes

Last Name | First Name | Date of Birth ____/____/____

Address | City | State

Primary Phone Number | Alternate Phone Number

• PRIMARY INSURANCE

Please indicate primary insurance:

❑ Medicaid ❑ Medicare ❑ Illinois Health Connect ❑ Harmony / HMO ❑ Private Insurance / PPO ❑ None

Policy Holder's Name | Policy/Recipient ID #

$_____ Co-Pay / Deductible Patient's Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

• SECONDARY INSURANCE

Name of Secondary Insurance (if applicable) | Policy/Recipient ID#

Policy Holder's Name | Relationship to Patient

INCOME VERIFICATION / HEAD OF HOUSEHOLD FAMILY SIZE / INCOME

Family Size: _____ **Family Combined Income**: $_____ Per Week / Month / Year **Annualized Income**: $_____

OFFICE USE ONLY:

Signature Forms

Patient Registration Form is Signed and Dated: ❑YES ❑NO

Medical Consent/HIPAA is Signed and Dated: ❑ YES ❑ NO

Sliding Fee Forms (Uninsured Patients)

Sliding Fee Application: ❑YES ❑NO ❑N/A

Current Income Documentation: ❑YES ❑NO ❑N/A

Current Financial Waiver: ❑ YES ❑ NO ❑ N/A

Slide has been assigned: ❑ YES ❑ NO ❑ N/A

Income Re-Certify Date: _____ Staff Signature: _____

Authorization: With my signature I certify that all of the information provided on the patient registration forms is correct to the best of my knowledge. I authorize the release of any medical or other pertinent information necessary to process claims pertaining to Aunt Martha's Health Center visits.

X _____ _____

Signature of Patient / Parent or Legal Guardian **Date**

AUNT MARTHA'S HEALTH CENTER

Consent for Medical Services

Patient Name: _____ Date of Birth: _____

I hereby consent to receive medical services from Aunt Martha's Health Center. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, Insurance companies, Reviewing and Accreditation Organizations and other Aunt Martha's programs.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Representative Signature Date

_____ _____
Staff Witness Signature Date

Receipt of Advance Directives Information, Client's Rights and Responsibilities and Notice of Privacy Practices

By signing below, I acknowledge that Aunt Martha's has provided me with a copy of an *Introduction to Advance Directives, Clients Rights and Responsibilities* and *Notice of Privacy Practices*. I have received my copies, I have read and understand the information provided to me.

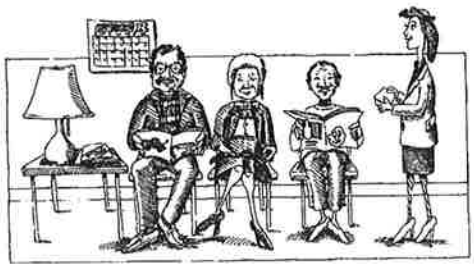
_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Representative Signature Date

_____ _____
Staff Witness Signature Date.

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
6. Do you have a seizure, brain, or nerve problem?	☐	☐	☐
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐	☐
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
9. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your healthcare provider to give you one! Bring this record with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

www.immunize.org/catg.d/p4065scr.pdf • Item#P4065 (7/06)

Information for Health Professionals about the Screening Questionnaire for Adults

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today?
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, or any vaccine?
History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) from a previous dose of vaccine or vaccine component is a contraindication for further doses. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. Local reactions (e.g., a red eye following instillation of ophthalmic solution) are not contraindications. For an extensive list of vaccine components, see reference 2.

3. Have you ever had a serious reaction after receiving a vaccination?
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community measles outbreak).

4. Do you have cancer, leukemia, AIDS, or any other immune system problem?
Live virus vaccines (e.g., MMR, varicella, and the intranasal live attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended for asymptomatic HIV-infected individuals who do not have evidence of severe immunosuppression. Immunosuppressed persons should not receive varicella vaccine or LAIV. For details, consult the ACIP recommendations (3, 4, 5).

5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?
Live virus vaccines (e.g., MMR, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 5). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can only be given to healthy non-pregnant individuals ages 5–49 years.

6. Do you have a seizure, brain, or nerve problem?
Tdap is contraindicated in persons who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For persons with stable neurologic disorders (including seizures) unrelated to vaccination, or for persons with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Inactivated influenza vaccine (TIV): if GBS has occurred within 6 weeks of prior TIV, vaccinate with TIV if at high risk for severe influenza complications; 3) LAIV: if GBS history, do not give LAIV; 4) MCV4: avoid vaccinating persons unless in recommended risk groups.

7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?
Certain live virus vaccines (e.g., MMR, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between immune globulin or blood product administration and MMR or varicella vaccination. (1)

8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?
Live virus vaccines (e.g., MMR, varicella, LAIV) are contraindicated in the month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive MMR or varicella vaccination should be instructed to practice careful contraception for one month following receipt of either vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent and immediate protection is needed (e.g., travel to endemic areas). Patients may be given Td routinely during 2nd or 3rd trimester if due for booster; if up to date and no history of Tdap, give 1 dose in immediate postpartum period, although some providers may choose to give Tdap during pregnancy. (1, 3, 4, 5, 7, 8)

9. Have you received any vaccinations in the past 4 weeks?
If the person to be vaccinated was given either live attenuated influenza vaccine (FluMist®) or an injectable live virus vaccine (e.g., MMR, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

References:

1. CDC. General recommendations on immunization. *MMWR* 2002; 51 (RR-2).
2. Table of Vaccine Components: www.cdc.gov/nip/publications/pink/appendices/b/excipient-table-2.pdf.
3. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
4. CDC. Prevention of varicella: updated recommendations of the ACIP. *MMWR* 1999; 48 (RR-6).
5. CDC. Prevention and control of influenza—recommendations of ACIP, at www.cdc.gov/flu/professionals/vaccination.
6. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients, *MMWR* 2000; 49 (RR-10), www.cdc.gov/nip/publications/hsct-recs.pdf.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
8. CDC. Prevention of varicella. *MMWR* 1996; 45 (RR-11).

PATIENT HEALTH QUESTIONNAIRE

Nine Symptom Depression Check List

(For patients ages 11 and older)

Patient Name: _____ Date: _____

1. Over the ***last two weeks***, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way **	☐	☐	☐	☐

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor or Health Care Clinician. If these kinds of thoughts happen when no one is available, go to a hospital emergency room, or call 911.*

2. If you have checked off ***any*** problem on this questionnaire so far, how ***difficult*** have these problems made it for you to work, take care of things at home, or get along with people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

(For Clinic Staff Only) *Add columns:* _____ + _____ + _____

Total # of Symptoms: _____ ***Total Score:*** _____

Staff Signature: _____ **Date:** _____

Provider Signature (if applicable): _____ **Date:** _____

Form: PHQ-9

DENTAL HEALTH ASSESSMENT

Name: _____ Today's Date: _____

Phone Number: _____ Date of Birth: _____

In order for Aunt Martha's to provide you quality health care, we need to know about you. Please answer the following questions honestly. Check the appropriate box for each question.

1. When is the last time you had a dental exam?
   - ☐ Less than 6 months ago
   - ☐ 6 months – 1 ½ years ago
   - ☐ More than 1 ½ years ago
   - ☐ I don't know

2. When is the last time you had your teeth cleaned?
   - ☐ Less than 6 months ago
   - ☐ 6 months – 1 ½ years ago
   - ☐ More than 1 ½ years ago
   - ☐ I don't know

3. Do your gums bleed when you brush your teeth?
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

4. Do you have pain in your mouth?
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

ASESORAMIENTO DE SALUD DENTAL

Nombre: _____ *Fecha de hoy:* _____

Número de teléfono: _____ *Fecha de nacimiento:* _____

Para que Aunt Martha's pueda proveerle calidad en su atención médica, por favor conteste las siguientes preguntas con honestidad. Marque la respuesta para cada pregunta.

1. *¿Cuándo fue la última vez que usted tuvo un examen dental?*
   - ☐ *Menos de 6 meses*
   - ☐ *6 meses – 1 ½ años*
   - ☐ *Mas de 1 ½ años*
   - ☐ *No sé*

2. *¿Cuándo fue la última vez que usted tuvo una limpieza de dientes?*
   - ☐ *Menos de 6 meses*
   - ☐ *6 meses – 1 ½ años*
   - ☐ *Mas de 1 ½ años*
   - ☐ *No sé*

3. *¿Sus encías sangran cuando se cepilla los dientes?*
   - ☐ *Sí*
   - ☐ *No*
   - ☐ *No sé*

4. *¿Tiene usted dolor en la boca?*
   - ☐ *Sí*
   - ☐ *No*
   - ☐ *No sé*

For office use only

Reviewed by: _____ _____ Referred? ☐ Yes ☐ No
Signature Date

Revised: 6/13/12

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

Date:	Name:	
Phone#:	DOB:	Age:

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ ringing in ears
- ☐ Hay fever/allergies/congestion
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pains/discomfort
- ☐ Palpitations
- ☐ Short of breath with exertion

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Respiratory
- ☐ Cough/wheeze
- ☐ Coughing up blood

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/diarrhea
- ☐ Pain in abdomen

Genitourinary
- ☐ Painful/bloody urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Recent back pain

Skin
- ☐ Rash
- ☐ New or change in mole

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep problem

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Endo
- ☐ Cold/heat intolerance
- ☐ Increase thirst/appetite

PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?
- ☐ Acid reflux (heartburn)
- ☐ Alcoholism/other addiction
- ☐ Allergies (environmental)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer (specify type_____)
- ☐ Coagulation (bleeding or clotting) problem
- ☐ Cholesterol problem
- ☐ Chronic low back pain
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Erectile dysfunction
- ☐ Heart disease (specify type_____)
- ☐ Hypertension (high blood pressure)
- ☐ Irritable bowel syndrome
- ☐ Migraines
- ☐ Osteopenia or Osteoporosis
- ☐ Prostate problem
- ☐ Thyroid problem
- ☐ Other problems (please list): _____

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of _____ (Please specify) Heart attack _____ Blood transfusion _____

Stroke (CVA) _____ Seizure _____

SURGICAL HISTORY: Please list all prior operations and dates. ☐ I have had no prior surgery.

Operation	Date

Operation	Date

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

(continued)

Name:	DOB:

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs.

☐ **I take no regular medications.**

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

☐ **I am not allergic to any medications.**

Medication	Reaction or Side Effect

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

☐ **I do not know my family history.**

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other close relatives
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Anesthesia problem	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐
Bleeding problem	☐	☐	☐	☐	☐	☐	☐
Cancer, Breast	☐	☐	☐	☐	☐	☐	☐
Cancer, Colon	☐	☐	☐	☐	☐	☐	☐
Cancer, Melanoma	☐	☐	☐	☐	☐	☐	☐
Cancer, other skin	☐	☐	☐	☐	☐	☐	☐
Cancer, Ovary	☐	☐	☐	☐	☐	☐	☐
Cancer, Prostate	☐	☐	☐	☐	☐	☐	☐
Cancer, (not noted)	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes, Type 1 (child)	☐	☐	☐	☐	☐	☐	☐
Diabetes, Type 2 (adult)	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Epilepsy (Seizures)	☐	☐	☐	☐	☐	☐	☐

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other close relatives
Genetic diseases	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Hay fever (Allergies)	☐	☐	☐	☐	☐	☐	☐
Hearing problems	☐	☐	☐	☐	☐	☐	☐
Heart Attack (CAD)	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐
Kidney diseases	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐
Stroke (CVA)	☐	☐	☐	☐	☐	☐	☐
Thyroid disorders	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

AUNT MARTHA'S HEALTH CENTER

SOCIAL HISTORY

Name:	DOB:

SUBSTANCES:

Tobacco Use

Please check one:

❑ I have never smoked.

❑ I have smoked, but rarely.
When was the last time? _____

❑ I have quit smoking. Quit Date: _____

❑ I currently smoke _____pack(s)/day, # of years: _____

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew

Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ Never ❑ Occasionally ❑ Regularly

Average # of drinks/week: _____ 5 oz. glasses of wine;
_____12 oz. cans of beer; _____1.5 oz. shots hard liquor

Is alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes

Have you ever used needles? ❑ No ❑ Yes

SEXUALITY:

Sexual Activity

Sexually Active: ❑ Yes ❑ No ❑ Not currently

Current sex partner(s) is/are: ❑ Male ❑ Female

Contraception and Protection

Birth control method: _____ ❑ None needed

If sexually active, do you practice safe sex? ❑ Yes ❑ No ❑ NA

Have you ever had any sexually transmitted diseases (STDs)?
❑ Yes ❑ No

If yes, please list: _____ Date: _____

Are you interested in being screened for sexually transmitted diseases?
❑ No ❑ Yes

Other concerns? _____
_____

SOCIOECONOMICS:

Ethnic Background (How would you best describe yourself?)
Check only one:

❑ Asian ❑ Black, Non-Hispanic ❑ Hispanic
❑ Native American ❑ Native Hawaiian & Other Pacific Islander
❑ White, Non-Hispanic ❑ Other ❑ Decline

Marital Status

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow
❑ Co-habiting ❑ Engaged ❑ Other: _____

Spouse/Partner's Name: _____

Number of children: _____

Who lives at home with you? _____

Occupation: _____

Education completed:

❑ Grade school ❑ High school ❑ College ❑ Graduate school

SAFETY:

Do you use seat belts?	❑ No	❑ Yes
Do you use a bike helmet regularly?	❑ No	❑ Yes
Is violence at home a concern for you?	❑ No	❑ Yes
Are you currently in a relationship?	❑ No	❑ Yes
If yes, do you feel safe in this relationship?	❑ No	❑ Yes
Do you have a gun in your home?	❑ No	❑ Yes

Other concerns? _____

EMOTIONS:

Over the **past two weeks**, how often have you been bothered by any of the following problems?

Please insert the appropriate number for each question, using the following scale:

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Little interest or pleasure in doing things? _____

Feeling down, depressed or hopeless? _____

EXERCISE:

How active are you?

❑ I get a cardiovascular work out 3 or more times per week.

❑ I walk daily but do not work out.

❑ I exercise or walk less than 3 times per week.

❑ I am not generally active.

❑ Other: _____

IMMUNIZATIONS:

Please list your most recent immunizations and include your best estimate of the month and year of each immunization.

Hepatitis A _____ Measles _____ Mumps _____ Rubella _____

Hepatitis B _____ MMR _____ Meningitis _____ Varicella (chicken pox)_____

HPV _____ Shingles_____ Tetanus/(td)(TdaP)_____ Other _____

Pneumovax (Pneumonia) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date: _____ Abnormal? ❑ Yes ❑ No

Sigmoidoscopy _____ or Colonoscopy _____ Date: _____ Abnormal? ❑ Yes ❑ No

Women: Mammogram _____ Date: _____ Abnormal? ❑ Yes ❑ No

Pap Smear _____ Date: _____ Abnormal? ❑ Yes ❑ No

Dexascan (osteoporosis) _____ Date: _____ Abnormal? ❑ Yes ❑ No

AUNT MARTHA'S HEALTH CENTER
An Introduction to Advance Directives:
Living Will and Durable Power of Attorney for Health Care

What is an Advance Directive?

An Advance Directive is a document that allows you to:

- To express your wishes about your healthcare in a form that will tell others how to care for you if and when the time comes that you are unable to make or communicate decisions for yourself.
- To give an "advance directive" means:
  - To give your directions ahead of time
- Two types of advance directives:
  - The Living Will
  - The Durable Power of Attorney for Health Care

Why is it a Good Idea to Have an Advance Directive?

An advance directive can help you prepare for decisions about medical care or life-threatening illness by declaring your wishes now.

If you choose not to have an advance directive, it is beneficial to discuss your wishes with persons (such as a guardian, spouse, adult children, and others close to you) who may be able make medical decisions on your behalf.

What is a Living Will?

- A written statement of your wishes regarding medical treatment if you have a terminal condition and death is imminent and you are unable to make decisions for yourself;
- If you are at the end of a terminal illness, allows you to choose the type of care you do or do not want (from among the reasonable and ethical medical care options offered by your doctor);
- Can provide instructions to your healthcare providers regarding your medical care if you are terminally ill, even if you do not wish to appoint a specific individual to serve as your agent under a Durable Power of Attorney for Health Care;
- Can be changed or revoked by you at any time;
- Is a document you are advised to share with one or more of the following persons:
  - A family member or close friend
  - Your doctor
  - Your lawyer
  - Your designated "agent" (your Durable Power of Attorney for Health Care) if you have one

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is:

- A written document that you can use to appoint a person of your choice (your "agent") who understands and agrees to make healthcare decisions for you;
- Becomes effective at whatever point in time that you state in your document, and as such
  - Can apply to a wide range of healthcare decisions (and is broader than a living will, which applies to terminal illness)
  - Allows you to rely on a trusted individual to decide what is best for you
- Concerns medical care decisions:
  - That you do not wish to make for yourself for whatever reason, or
  - That must be made when you are very sick and unable to communicate decisions for yourself
- Requires your agent to honor your wishes about healthcare as you have instructed
- Can be changed or revoked by you at any time

Where Can I Get More Information?

For information about different types of advance directives (Living Will, Durable Power of Attorney for Health Care, Do Not Resuscitate orders (DNR), refer to the following sources:

1. Your lawyer or legal aid service
2. Your county or state health department
3. Illinois Department of Public Health
   - Email: www.idph.state.il.us
   - Phone: 217-782-4977
   - Fax: 217-782-3987
   - Mail: 535 W. Jefferson St.
     Springfield, IL 62761

AUNT MARTHA'S HEALTH CENTER
CLIENT'S RIGHTS AND RESPONSIBILITIES

Aunt Martha's Health Center is dedicated to providing clients with the best possible care to meet their identified needs. To accomplish this, we believe it is critical to include our clients and parents/legal guardians, when applicable, in all decisions that directly impact our team.

It is the duty of Aunt Martha's staff to inform you of your rights and program responsibilities before the commencement of services in a language or method of communication that you will understand. These rights are protected and promoted by agency staff.

- You have the right to Confidentiality of information which is governed by the Health Insurance Portability and Accountability Act of 1996 and state law where applicable. Your personal information will be used only as described in the Notice of Privacy Practices, unless written authorization is given to you or your legal guardian, if applicable, except as required by law.
- You have the right to be informed of the nature, availability (including hours which care is available) and goals of all services to which you are otherwise entitled through the agency or other resources.
- You have the right to receive services with adequate and human care in the least restrictive environment.
- You have the right to receive services regardless of age, sex, race, religious belief, ethnic origin, or impairment. However, if you are under the age of 18, your parent or legal guardian's permission is needed, unless you are seeking Family Planning services and you are 12 years of age or older.
- You have the right to be free from abuse, neglect, or exploitation. You will not be subjected to any type of punishment that violates your rights such as corporal punishment, ridicule, humiliation, verbal abuse, or any other means of discipline which would lessen your sense of dignity and value as a person.
- You have the right to view your client record and examine its contents in the presence of a staff member qualified to interpret the file contents. You may request that a statement of clarification be included in your record should you find any discrepancies.
- You or your legal guardian have the right to file a grievance or appeal decisions of the provider up to and including the executive director or comparable position and be informed of the outcome of the petition.
- You or your legal guardian has the right to refuse services, including medications. You will be informed of alternative services available and the risks of such alternatives, if any, as well as the possible consequences of refusal of such services.
- Treatment and/or services will not be denied, reduced, suspended, or terminated for exercising any of your rights.
- You will be made aware of any fees or payment policies that pertain to the services provided. In clinical programs, an inability to pay will not be the sole determining factor in your admission or discharge from any services.
- You have the right and responsibility to be involved in any and all care decisions.
- You have the right to be informed about any financial programs related to your care, treatment, or services.
- You have the responsibility to provide relevant information to clinic staff and to the physician or medical provider to the extent that you are able.
- You have the responsibility to ask questions if you do not understand instructions that are given to you.
- You have the responsibility to accept consequences that may occur as a result of decisions that you make, actions that you take, or inaction.
- You have the responsibility to follow rules and regulations specific to our facility.
- You have the responsibility to show respect to other patients and staff.
- You have the responsibility to make an effort to pay treatment related bills for which you are responsible.

NOTICE OF PRIVACY PRACTICES

Aunt Martha's Health Center is a covered entity under HIPAA (Health Insurance Portability and Accountability Act). As a covered entity, Aunt Martha's is committed to ensuring that your private health information is treated confidentially. This notice describes instances when your health information may be disclosed (used outside of Aunt Martha's). Other than the disclosures described in this notice, your health information will not be disclosed without your signed authorization.

Use of Information for Treatment, Payment and Operations

1. In order to provide good medical care to you (treatment), obtain payment for services (payment), and ensure quality and efficiency in our daily functions (operations), there will be times when we must share information outside of this organization:
    a. An example which may occur under treatment would be calling a physician or hospital to which we are referring you and providing them with information about your condition.
    b. For payment purposes, we might send information to your insurance company, required in order to process your bill.
    c. For operations, we might allow your chart to be reviewed by an external reviewer or auditor.
2. In the above instances, your personal health information may be disclosed. Under each of these circumstances, the entities that review your information will be either bound by federal law or otherwise have a responsibility to keep your personal information confidential.
3. Information that we may release under these circumstances would not be limited to and could include information regarding HIV infection, substance abuse, and /or psychiatric illness.
4. You may request restrictions beyond those stated in this notice but our organization is not required to abide by the restrictions requested unless we agree to do so.

The Right to Inspect and Amend Records

- You have the right to inspect your medical/client record or any other document owned by Aunt Martha's that contains your personal health information with rare exceptions.
- If you believe that any information inspected is inaccurate, you have the right to request that the information be changed so that it is accurate.
- A request to inspect or amend your health information must be in writing. Should you make such a request, it will be evaluated by Aunt Martha's Privacy Officer or designee to determine if the request to inspect your health information and/or the requested change in your health information should be allowed.
- You will be informed of a decision (for inspection or amendment/change of record) within a reasonable period of time.
- If a decision is made to change the information as requested, an effort will be made to inform other entities who may receive inaccurate information.
- However, if it is determined that no change is warranted, you will be informed of this decision as well. You may appeal this decision by resubmitting the request for the change in writing and stating in that request that you are now appealing a previous decision.
- Upon receipt of the second request, the records will be reevaluated by a licensed physician who was not involved in your treatment or in the decision to deny the initial request. The decision at this second level of review will be final.

Disclosure of Research

- It is possible that your health information might be accessed by a researcher.
- Such access will not be allowed under any circumstances unless the researcher has clearly demonstrated that your heath information will be treated confidentially and that protective measures are put in place to ensure that unauthorized access does not occur.
- In these situations, if feasible, you will be contacted and your permission will be asked to allow your information to be utilized for this purpose.
- Whether you allow or don't allow your information to be used, your services at Aunt Martha's will not be affected. Your treatment will in no way be conditioned upon your approval.

- In situations where it is feasible to obtain your approval, your information may still be used (but not in instances where you have requested that your information not be used) provided that the researcher has demonstrated that appropriate steps will be taken to protect your identity, that protective measures are in place to prevent unauthorized access, and that any information pertaining to your identity will be destroyed as early in the research as possible.
- Any disclosure beyond that described above will generally require you to sign an authorization form except under rare and extenuating circumstances.
- Aunt Martha's has formed a Corporate HIPAA Compliance Committee which is responsible for overseeing the implementation of Aunt Martha's HIPAA compliance efforts and ensuring that your personal health information is treated confidentially. Members of this committee, including those who are responsible for investigating complaint, are listed below:
    - Chief Executive Officer — Raul Garza
    - Medical Director — Jennifer Byrd
    - Complaint Recipient — Ernest Gonzalez

- You may submit a complaint verbally or in writing to either the complaint recipient or to this location. If you leave a voicemail message, include your name, patients/client's name and details about the complaint.
- Furthermore, at your discretion, you may complain to any members of the committee listed above. Additionally, if you believe that your rights to privacy have been violated, you have the right to complain to the Secretary of the Department of Health and Human Services in the Office of Civil Rights.
- This privacy notice may be subject to change. If a change should occur, the change will be posted in our waiting area and on our website at the time of implementation or as soon as possible after implementation. You may request a current notice at any time verbally or in writing.