FAU/CHC Community Health Clinic

REGISTRATION PACKET

Dear Patient: We are a non-profit clinic that provides low-cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. This practice serves all patients regardless of inability to pay. Due to new federal reporting regulations; the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Patient Information: Today's Date:

Last Name:

First Name: MI: Data Of Birth:

Address: City: Zip Code:

Home Phone: Cell Phone:

Email Address: SSN: Birth Sex: □ Male □ Female

Living Arrangements: (Please check one)

○ **Shelter** (safe havens, temporary overnight housing, armories) ○ **Transitional** (center, community, Home) ○ **Other** (hotel, motel day-to-day single room occupancy)	○ **Doubling Up** (living with other people for a temporary period and move often) ○ **Street** (sidewalk, car, park, doorway, public or abandon building)	○ **Permanent Resident** (own, rent, apartment/room/house)

Transportation: (Please check one)

- ○ **Car**
- ○ **Bus-line**
- ○ **Walk/Bike**
- ○ **Transport Van (Insurance)**

Ethnic Origin: (Please check one) **Hispanic:** □ Yes □ No

Race: (please check all that apply)

□ Caucasian □ Asian □ Pacific islander □ Native Hawaiian

□ Black or African-American □ American Indian/Alaskan Native □ Other/Choose Not to-Disclose

Gender Identity:

□ Male □ Transgender Male/Female-to-Male □ Other: _______________

□ Female □ Transgender Female/Male-to-Female □ Choose Not to-Disclose

Sexual Orientation:

□ Straight □ Bisexual □ Don't know

□ Lesbian or Gay □ Other: _______________ □ Choose Not to-Disclose

Marital Status: □ Married □ Single □ Divorced □ Widowed

Spouse or Parent/Guardian Information (if applicable): Last Name: ______________________ First Name: ________________________ DOB: __________ Work Phone: _______________________ Cell Phone: ____________________
Primary Language: ______________________
Health Insurance (please check): □ Medicare □ Medi-Cal □ None □ Other: _________________
Emergency Contact: Last Name: ______________________ First Name: ________________________
Relation to Patient: ________________________ Phone Number: ____________________

In case of an emergency, FAU/NCHA Community. Clinics will provide your medical records to a hospital or other medical institution if you are unable to make medical decisions on your own behalf.
If you wish not to have your medical records sent on your behalf: please check this box

□ In case of an emergency, I do not want my medical records sent on my behalf.

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name____Date____________

Date Of Birth__________________ Primary Care Physician____

Do you give permission for ongoing regular updates to be provided to your primary care physician?________________

Current Therapist?______________________________ Therapist's Phone_________________________________

What are the problems(s) for which you are seeking help?

1.____

2.____

3.____

What are your treatment goals?

____
____
____
____

Current Symptoms checklist: (check once for any symptoms present, twice for major symptoms)

o Depressed Mood	o Racing thoughts	o Excessive worry
o Unable to enjoy activities	o Impulsivity	o Anxiety attacks
o Sleep pattern disturbance	o Increase risky behavior	o Avoidance
o Loss of interest	o Increased libido	o Hallucinations
o Concentration/forgetfulness	o Decrease need for sleep	o Suspiciousness
o Change in appetite	o Excessive energy	o ________________
o Excessive guilt	o Increased irritability	o ________________
o Fatigue	o Crying spells	
o Decreased libido		

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? □ Yes □ No
If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? □ Yes □ No
How often do you have these thoughts?____
When was the last time you had thoughts of dying?____
Has anything happened recently to make you feel this way?____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?__________________
Would anything make it better?____
Have you ever thought about how you would kill yourself?____
Is the method you would use readily available?____
Have you planned a time for this?____
Is there anything that would stop you from killing yourself?____
Do you feel hopeless and/or worthless?____
Have you ever tried to kill or harm yourself before?____
Do you have access to guns? If yes, please explain.____

Past Medical History:

Allergies_________________________ Current____________ Height___________

List ALL Current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: ____

Current Medical problems: ____

Past medical problems, nonpsychiatric hospitalization, or surgeries: ____

Have you ever had an EKG? ◻ Yes ◻ No If yes, when ________
Was the EKG? ◻ normal ◻ abnormal or ◻ unknown?

For women only: Date of last menstrual period ________ Are you currently pregnant or do you think you might be pregnant? ◻ Yes ◻ No. Are you planning to get pregnant in the near future? ◻ Yes ◻ No
How many times have you been pregnant? ________ How many live births? ________

Do you have any concerns about your physical health that you would like to discuss with us? ◻ Yes ◻ No
Date and place of last physical exam: ____

Personal and Family medical History:

	You	Family	Which Family Member?
Thyroid Disease	◻	◻	________________
Anemia	◻	◻	________________
Liver Disease	◻	◻	________________
Chronic Fatigue	◻	◻	________________
Kidney Disease	◻	◻	________________
Diabetes	◻	◻	________________
Asthma/respiratory problems	◻	◻	________________
Stomach or intestinal problems	◻	◻	________________
Cancer (type)____________	◻	◻	________________
Fibromyalgia	◻	◻	________________
Heart Disease	◻	◻	________________
Epilepsy or seizures	◻	◻	________________
Chronic Pain	◻	◻	________________
High Cholesterol	◻	◻	________________
High blood pressure	◻	◻	________________
Head trauma	◻	◻	________________
Liver problems	◻	◻	________________
Other____________________	◻	◻	________________

Is there any additional personal or family medical history? □ Yes □ No If Yes, please explain:

____

____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

____

____

Past Psychiatric History:

Outpatient treatment □ Yes □ No If yes, please describe when, by whom, and nature of treatment.

Reason Date Treated By Whom

____

____

____

Outpatient treatment □ Yes □ No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

____

____

____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do· remember).

Date Dosage Response/Side Effects

Antidepressants

Prozac (fluoxetine)____

Zoloft (sertraline) ____

Luvox (fluvoxamite) ____

Paxil (paroxetine) ____

Celexa (citalopram) ____

Lexapro (escitalopram) ____

Effexor (venlafaxine) ____

Cymbalta (duloxetine) ____

Wellbutrin (bupropion) ____

Remeron (mirtazapine) ____

Serzone (nefazodone) ____

Anafranil (clomipramine) ____

Pamelor (nortrptyline) ____

Tofranil (imipramine) ____

Elavil(amitriptyline) ____

Other ____

Mood Stabilizers

Tegretol (carbamazepine) ____

Lithium____

Depakote (valproate) ____

Lamictal (lamotrigine) ____

Tegretol (carbamazepine) ____

Topamax (topiramate) ____

Other____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers Date Dosage Response/Side Effects

Seroquel (quetiapine) ____

Zyprexa (olanzepine) ____

Abilify (aripiprazole) ____

Clozaril (clozapine) ____

Haldol (haloperidol) ____

Prolixin (fluphenazine} ____

Risperdal (risperidone) ____

Other ____

Sedative/Hypnotics

Ambien (zolpidem) ____

Son at a (zaleplon) ____

Rozerem (ramelteon) ____

Restoril (temazepam) ____

Desyrel (trazodone) ____

Other____

ADHD medications

Adderall (amphetamine) ____

Concerta (methylphenidate) ____

Ritalin (methylphenidate) ____

Strattera (atomoxetine) ____

0ther____

Antianxiety medications

Ativan (lorazepam) ____

Klonopin (clonazepam) ____

Valium (diazepam) ____

Tranxene (clorazepate) ____

Buspar (buspirone) ____

Other ____

Your Exercise Level:

Do you exercise regularly? □ Yes □ No

How many days a week do you get exercise? ________________________________

How much time each day do you exercise? ________________________________

What kind of exercise do you do? ________________________________

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	□ Yes □ No	Schizophrenia	□ Yes □ No
Depression	□ Yes □ No	Post-traumatic stress	□ Yes □ No
Anxiety	□ Yes □ No	Alcohol abuse	□ Yes □ No
Anger	□ Yes □ No	Other substance abuse	□ Yes □ No
Suicide	□ Yes □ No	violence	□ Yes □ No

If yes, who had each problem? ________________________________

____

Has any family member been treated with a psychiatric medication □ Yes □ No If yes, who was treated, what medication did they take and how effective was the treatment? ________________________________

____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? □ Yes □ No
If yes, for which substances? ____
If yes, where were you treated and when? ____
____
How many days per week do you drink any alcohol? ________________
What is the least number of drinks you will drink in a day? ____________
What is the most number of drinks you will drink in a day? ____________
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____________
Have you ever felt you ought to cut down on your drinking or drug use? □ Yes □ No
Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No
Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ Yes □ No
Do you think you may have a problem with alcohol or drug use? □ Yes □ No
Have you used any street drugs in the past 3 months? □ Yes □ No
If yes, which ones? ____
Have you ever abused prescription medication? □ Yes □ No
If yes, which ones and for how long? ____
____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	□	□	________________________________
Cocaine	□	□	________________________________
Stimulants (pills)	□	□	________________________________
Heroin	□	□	________________________________
LSD or Hallucinogens	□	□	________________________________
Marijuana	□	□	________________________________
Pain killers (not as prescribed)	□	□	________________________________
Methadone	□	□	________________________________
Tranquilizer/sleeping pills	□	□	________________________________
Alcohol	□	□	________________________________
Ecstasy	□	□	________________________________
Other	□	□	________________________________

How many caffeinated beverages do you drink a day? Coffee _________Sodas _________Tea ________

Tobacco History:
How you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No How many packs per day on average? _________ How many years? _________
In the past? □ Yes □ No How many years did you smoke? _________ When did you quit? _________

Pipe, cigars, or chewing tobacco: Currently? □ Yes □ No In the past? □ Yes □ No
What Kind? _________ How often per day on average? _________ How many years? _________

Family Background and Childhood History:

Were you adopted? □ Yes □ No Where did you grow up? ____

List your siblings and their ages: ____

____

What was your father's occupations? ____

What was your mother's occupation? ____

Did your parents' divorce? □ Yes □ No If so, how old were you when they divorced? ____________________ If your parents divorced, who did you live with? ____

Describe your father and your relationship with him: ____

____

Describe your mother and your relationship with her:____

____

How anyone old were in you left home?____

Has anyone in your immediate died? ____

Who and when?____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? □ Yes □ No

Please describe. When, where and by whom: ____

____

Educational History:

Highest Grade Completed? _______ Where? ___________________________________

Did you attend college? ________Where? ___________________________Major? ____________________________

What is your highest educational level or degree attained?____

Occupational History:

Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired

How long in present position? ______________________________________

What is/was your occupation? ______________________________________

Where do you work? ____

Have you ever served in the military? ___ If so, what branch and when? ___________________________________

Honorable discharge □ Yes □ No Other type discharge ___________________________________

Relationship History and Current Family:

Are you currently: □ Married □ Partnered □ Divorced □ Single □ Widowed

How long? ______

If not married, are you currently in a relationship? □ Yes □ No If yes, how long? ______________________________

Are you sexually active □ Yes □ No

How would you identify your sexual orientation?

□ Straight/heterosexual □ lesbian/gay/homosexual □ bisexual □ transsexual

□ Unsure/questioning □ asexual □ other □ prefer not to say

What is your spouse or significant other's occupation?____

Describe your relationship with your spouse or significant other:____

Have you had any prior marriages? □ Yes □ No If so how many?______________________________

How long?____

Do you have children? □ Yes □ No If yes, list ages and gender:____

____

Describe your relationship with your children:____

List everyone who currently lives with you:____

Legal History:

Have you ever been arrested? ____

Do you have any pending legal problems? ____

Spiritual Life:

Do you belong to a particular religion or spiritual group? □ Yes □ No

If yes, what is the level of your involvement?

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? □ more helpful □ Stressful

Is there anything else that you would like to let us know?

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Signature____Date_____________________

Guardian Signature (if under 18)

____Date________________________

Emergency Contact ____ Telephone # _______________________

For Office Use Only:

Reviewed by ____ Date ___________________________

Reviewed by ____ Date ___________________________

PATIENT HEALTH QEUSTIONNAIRE – 9
(PHQ – 9)

Over the last 2 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
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 over eating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let you 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

FOR OFFICE CODING __0____ + ______ + ______ + ______
=Total Score: _____

If you have check off any problems, how difficulty 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc_ No permission required to reproduce, translate, display or distribute.

The FAU Employees and or agents that provide medical ·care and treatment have permission to speak to the following family members/friends in reference to my medical care:

_______________________________________ Relationship_____________________________________
_______________________________________ Relationship_____________________________________

____
Patient Signature   Date

I also give permission for staff to…

- Leave message on the home answer machine □ Yes □ No
- Leave message at work □ Yes □ No
- Leave message on cell phone □ Yes □ No

ADULT CONSENT FOR TREATMENT

Name:________________________________ DOB:________________________________

I, ____authorize and do voluntarily consent to and authorize the FAU Christine E. Lynn College of Nursing Community Health Center to provide preventive, diagnostic, and therapeutic procedures and treatment. These procedures and treatment are considered necessary or advisable in the judgment of the attending Health Care Provider, his/her assistants or designees.

I understand that no guarantees have been made to me as to the results of the treatment or examinations.

I understand the consent form and accept its contents.

___________________________ ____ ________________________

Signature Relationship of representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative) ____________ Patient's Student ID/Z# ____________ Date ____________

Print Name of Patient (or Authorized Personal Representative ____________ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) ____________

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility.

The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: physicians, residents, fellows, healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians, who will at all times be under the exclusive supervision and control of FAU. I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Signature of Patient (or Authorized Personal Representative) ____________ Date ____________

Print Name of Patient (or Authorized Personal Representative) ____________ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) ____________

Printed Name of Witness ____________ Date ____________

AGREEMENT TO MEDIATE

In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Signature of Patient (or Authorized Personal Representative) ____________ Date ____________

Print Name of Patient (or Authorized Personal Representative) ____________ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) ____________

Printed Name of Witness ____________ Date ____________