

# Family Tree HealthCare Patient Information Form

## PERSONAL INFORMATION

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address \_\_\_\_\_

Marital status: Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Other: \_\_\_\_\_

## INSURANCE INFORMATION

Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

## DO YOU HAVE ADDITIONAL INSURANCE?

YES \_\_\_\_\_ NO \_\_\_\_\_

(If yes please fill out the following section)

Secondary insurance name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective date: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

## PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

I consent to treatment necessary for the care of the aforementioned patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company; I allow fax transmittal of my records, if necessary. I acknowledge full financial responsibility for services rendered by Family Tree HealthCare. I understand that payment and charges incurred responsible attorney fees and collection costs in the event of default of payment charges. I further authorize and request that insurance payments be made directly to Family Tree HealthCare . I have read and fully understand the above consent from, treatment, financial, responsibility, release of medical information and insurance authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient # \_\_\_\_\_

To help us meet all your healthcare needs/ please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____ Place of birth _____ Highest level of school _____ Occupation _____ Previous occupation _____ Marital Status _____ Hobbies _____ Exercise/ recreation _____ Habits: Smoking (type & amount per day) _____ If former smoker, date quit _____ Alcohol (type & amount per week) _____ Caffeine (type & amount per day) _____ Street drugs (type & amount per day) _____ Usual weight _____ Date of last Dental exam _____ Please list all allergies (foods, drugs, and environment) _____ _____ _____	When was your last Physical exam? _____ Name of doctor _____ Phone _____ please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none <input type="checkbox"/> _____ _____ Please list all medicines you are currently taking (include nonprescription drugs): none <input type="checkbox"/> _____ _____ Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred: none <input type="checkbox"/> _____ _____ _____
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**Chief Complaints**

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

\_\_\_\_\_

\_\_\_\_\_

**Past medical history**

Have you ever had the following? (Circle "no" or "yes". Leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infection Mono	no	yes
Whooping cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet fever	no	yes	Polio	no	yes	Mitral Value Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma transfusions	no	yes	Ulcer	no	yes
Rheumatic fever	no	yes	Back trouble	no	yes	Kidney Disease	no	yes
Heart Disease	no	yes	High or low blood pressure	no	yes	Thyroid disease	no	yes
Arthritis	no	yes	Hemorrhoids	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes	Date of last chest x-ray _____			Any other disease (please list) _____	no	yes
Anemia	no	yes	Asthma	no	yes	_____		
Bladder infections	no	yes				_____		
Epilepsy	no	yes				_____		

**Family history**

Has any blood relative had any of the following (Circle "no" or "yes". Leave blank if uncertain.)

			<u>Relationship</u>			<u>Relationship</u>
Cancer	no	yes	_____	Stroke	no	yes
Tuberculosis	no	yes	_____	Epilepsia	no	yes
Diabetes	no	yes	_____	Allergies	no	yes
Heart disease	no	yes	_____	Anemia	no	yes
High blood pressure	no	yes	_____	Bleeding tendency	no	yes
						_____

# HEALTH HISTORY

(Circle "no" or "yes". Leave blank if uncertain)

or age of death \_\_\_\_\_ if deceased, cause of death \_\_\_\_\_

		<u>Relationship</u>	
Asthma	no	yes	Father _____
Chronic long Disease	no	yes	Mother _____
Drug or alcohol problem	no	yes	Siblings _____
Mental illness	no	yes	_____
Leukemia	no	yes	_____
Migraine headaches	no	yes	_____
Obesity	no	yes	Spouse _____
Thyroid Disease	no	yes	_____
Ulcer	no	yes	Children _____
Depression	no	yes	_____
High Cholesterol	no	yes	
Kidney Disease	no	yes	
Glaucoma	no	yes	
Gout	no	yes	

**Do you have now or have you had within the past year:**

(Circle "no" or "yes", leave Blank if uncertain.)

Weakness or paralysis	no	yes	Bloody sputum	no	yes	Joint pain or stiffness	no	yes
Tire easily or weakness	no	yes	Wheezing	no	yes	Swollen Joints	no	yes
Recent weight changes	no	yes	Chest pain or discomfort	no	yes	Muscle cramps or spasms	no	yes
Change in appetite	no	yes	Purple fingers or lips	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Swelling of hands feet or ankles	no	yes	Seizures	no	yes
Persistent fever	no	yes	Difficulty breathing	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Heart Palpitations	no	yes	Memory loss	no	yes
Skin Rash	no	yes	Leg cramps walking and/or rest	no	yes	Poor coordination	no	yes
Skin trouble or changes	no	yes	Enlarged veins	no	yes	Dizziness or fainting spells	no	yes
Change in nails or hair	no	yes	Difficulty swallowing	no	yes	<b>Men only:</b>		
Headaches	no	yes	Heartburn	no	yes	Discharge from penis	no	yes
Easy bleeding or bruising	no	yes	Frequent Belching	no	yes	Pain or lump in testicles	no	yes
Double vision	no	yes	Abdominal cramping	no	yes	impotence	no	yes
Blurred vision	no	yes	Nausea	no	yes	<b>Women only:</b>		
Eye pain	no	yes	Vomiting	no	yes	Age period began	_____	
Infected eye	no	yes	Vomiting or coughed up blood	no	yes	How many days do periods last?	_____	
Do you wear glasses or contacts	no	yes	Chronic Diarrhea	no	yes	How days between periods?	_____	
When was your last eye exam	_____		Chronic constipation	no	yes	Is the flow heavy	no	yes
Ringing in ears	no	yes	Rectal bleeding	no	yes	Do you bleed or spot		
Discharge from ears	no	yes	Black tarry stools	no	yes	between periods	no	yes
Ear pain	no	yes	Dark urine	no	yes	Do you have pain or cramps	no	yes
Decrease in hearing	no	yes	Yellow jaundice	no	yes	Date if last period?	_____	
Frequent nosebleeds	no	yes	Frequent Urination (day)	no	yes	Date of last pelvic exam?	_____	
Frequent clods	no	yes	Frequent Urination (night)	no	yes	Date of last mammogram?	_____	
Sinus trouble	no	yes	increase in thirst	no	yes	Any itching in vaginal area?	_____	
Loss of smell	no	yes	Painful urination	no	yes	Pain with intercourse?	no	yes
Persistent Hoarseness	no	yes	Leakage of urination	no	yes	type of birth control used?	_____	
Sore throat	no	yes	Difficulty in starting urine	no	yes	Number of pregnancies?	_____	
Sore tongue or gums	no	yes	Blood in urine	no	yes	Number of full term births?	_____	
Lump or discharge from breast	no	yes	Lack of sex drive	no	yes	Number of preterm term births?	_____	
Chronic or frequent cough	no	yes	Hemorrhoids	no	yes			
Shortness of breath	no	yes	Backaches	no	yes			

X

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

# Family Tree HealthCare

## NOTICE OF PRIVACY PRACTICES

### **To our patients:**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance portability and Accountability Act of 1996 (HIPPA)

### **Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

### **Use and disclosure of your health information certain special circumstances**

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrator order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For worker's Compensation and similar programs.

### **Your rights regarding your health information**

1. Communications. You can request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our

disclosure of your health care information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including patient medical records and billing records, but not including psychotherapy notes.

You must submit your request in writing to:

Physical Address

Family Tree HealthCare  
7002 S Central Ave  
Phoenix AZ 85042  
(602) 499-4221  
(602)-268-6298 fax

Mailing Address

Family Tree HealthCare  
7002 S Central Ave  
Phoenix, AZ 85042

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as the long as the information is kept by or for our practice. To request an amendment you request must be written and submitted to B-Healthy Medical. You must provide with reason that supports your request for amendment.
5. You have a right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this notice at any time. To obtain a copy of the notice contact our front desk.
6. You have a right to file a complaint. If you believe you privacy rights have been violated, you may file a complaint with our practice, or with the secretary of the Department of Health and Human Services. To file a complaint with our practice contact B-Healthy Medical as above for handling complaints. All complaints must be submitted in writing you will not be penalized for filling a complaint.
7. Right to provide an authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Family Tree HealthCare as above information provided for further information.

I hereby acknowledge that I have been presented with a copy of Family Tree HealthCare Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" 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. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, TOTAL:   
please refer to accompanying scoring card).

<b>10.</b> If you checked off <i>any problems</i> , how <i>difficult</i> 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	_____

# PHQ-9 Patient Depression Questionnaire

## For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

## *Consider Major Depressive Disorder*

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

## *Consider Other Depressive Disorder*

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

## To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

## Scoring: add up all checked boxes on PHQ-9

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

## Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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