CARELINK NM
YOUR CARE. OUR COMMUNITY.

Clinical Screen

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

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

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

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

Please circle your answer

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

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

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

Anxiety Screen				
Over the last two weeks, how often have you been bothered by any of the following problems? (please circle your answer)				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless that it is hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid, as if something awful might happen	**0**	**1**	**2**	**3**

Audit-10					
Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. **These questions are about your drinking habits. We've listed the serving size of one drink below.**					
Standard serving of one drink: **12 ounces of beer or wine cooler** **1.5 ounces of 80 proof liquor** **5 ounces of wine** **4 ounces of brandy, liqueur or aperitif**					
Please circle your answer					
How often do you have one drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times a month**	**2-3 times a week**	**4+ times a week**
How many drinks containing alcohol do you have on a typical day when you are drinking?	**1 or 2**	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
How often do you have four or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
How often during the last year have you…					
found that you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
failed to do what was normally expected from you because of drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
needed a first drink in the morning to get yourself going after heavy drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
had a feeling of guilt or remorse after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
been unable to remember what happened the night before you had been drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**

Have you or someone else been injured as a result of your drinking?	**No**	**Yes, but not in the last year**	**Yes, during the last year**
Has a relative, friend, doctor, or health worker been concerned about your drinking or suggested you cut down?	**No**	**Yes, but not in the last year**	**Yes, during the last year**

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

Depression Survey				
Over the last two weeks, how often have you been bothered by any of the following problems? (please check your answer and circle the boxes that apply to you)				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
☐ **Trouble falling or staying asleep or,** ☐ **Sleeping too much**	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
☐ **Poor appetite or,** ☐ **Overeating**	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**

	Not at all	Several days	More than half the days	Nearly every day
☐ Moving or speaking so slowly that other people could have noticed or, ☐ The opposite-being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
☐ Thoughts that you would be better off dead or, ☐ Hurting yourself in some way	0	1	2	3

PC-PTSD		
In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:		
Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Child Member Information		
Background		
What brought you in for services today?		
Would you like an interpreter?	Yes	No
Do you have a developmental/intellectual disability?	Yes	No
If Yes, do you have an Individual Service Plan related to your	Yes	No
Do you have an Emergency Crisis Plan? (if yes, please provide a copy)	Yes	No
Were you referred?	Yes	No
If yes, by whom were you referred?		
Nursing Facility Level of Care (NFLOC)?		
Height and Weight		
Height (in inches)		
Weight (in pounds)		
Exam Dates		
Date of last physical exam	_ _/_ _/_ _ _ _	Don't Know
Date of last dental exam	_ _/_ _/_ _ _ _	Don't Know
Date of last vision exam	_ _/_ _/_ _ _ _	Don't Know
Date of last hearing exam	_ _/_ _/_ _ _ _	Don't Know
Date of last bone density exam	_ _/_ _/_ _ _ _	Don't Know

Care Team
Care Coordinator
Name

Primary Care Provider				
Name				
Phone Number (###-###-####)				
Behavioral Health Therapist				
Name				
Phone Number (###-###-####)				
Plan of Care				
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Short-term Goals; 0-3 Months				
Goal				
Intervention				
Progress				
Outcome				
Date Initiated	_ _/_ _/_ _ _ _		Date Targeted	_ _/_ _/_ _ _ _
Date Updated	_ _/_ _/_ _ _ _		Date Achieved	_ _/_ _/_ _ _ _
Long-term Goals; 3-12 Months				
Goal				

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

Intervention						
Progress						
Outcome						
Date Initiated	_ _/_ _/_ _ _ _		**Date Targeted**	_ _/_ _/_ _ _ _		
Date Updated	_ _/_ _/_ _ _ _		**Date Achieved**	_ _/_ _/_ _ _ _		
Future Opportunities						
Demographics/Psychosocial						
Name of person filling out assessment						
Relationship of person filling out assessment to the person coming in today			**Self**	**Parent/ Guardian**	**Friend**	**Other**
If Other please describe						
Are there cultural or religious preferences that you would like your provider to be aware of today?				**Yes**	**No**	**Prefer not to answer**
If Yes please describe						
General Health Information						
Are you currently in any physical pain?					**Yes**	**No**
How much pain are you in today? Please enter best response, with 0 being no pain and 10 being the most pain you have ever had.						
Where is your pain?						
Have you ever had a traumatic brain injury (head injury, concussion)?					**Yes**	**No**
Do you need help with transportation to appointments?					**Yes**	**No**
In general, would you say your physical health is:	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Prefer not to answer**
In general, would you say your mental health is:	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Prefer not to answer**
Have you had any psychiatric hospitalization in the last 6 months?				**Yes**	**No**	**Prefer not to answer**
Are you currently taking atypical psychotropic medications, such as Ability, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?				**Yes**	**No**	**Prefer not to answer**
How much are you bothered by medication side effects (for example, shaking and trembling, not being able to think clearly, gaining or losing weight, or sexual problems)?		**Not bothered at all**	**Bothered a little**	**Bothered moderately**	**Bothered a lot**	**Prefer not to answer**

Diagnosis				
Diagnosis				
Member Goals				
Member Goals				
Home Life				
How may people live in your home, including you?				
Who lives in your home with you? (circle all that apply)				
Mother	Stepmother	Father		
Stepfather	Two Mothers	Two Fathers		
Mother's boyfriend	Father's girlfriend	Boyfriend/partner		
Girlfriend/partner	Spouse/Partner's Mother or Father	Grandmother(s)		
Grandfather(s)	Aunt(s)	Uncle(s)		
Cousin(s)	Foster Parent(s)	Friend(s)		
Other Relative(s)	Pet(s)	None of these apply		
What is your current living arrangement? (circle one)				
Homeless		Dependent Living		
Dependent Living: Residential Care		Dependent Living: Foster Care/Foster Home		
Dependent Living: Crisis Residence		Dependent Living: Institutional Setting		
Dependent Living: Jail/Correctional Facility/Other		Dependent Living: Private Residence		
Independent Living	Unknown	Private Residence, Living Arrangement not Specified		
Have you been homeless at any time in the last 6 months?		Yes	No	Prefer not to answer
Are you having any problems at home? (circle all that apply)				
Violence	Money	Fighting		
House	Food	Gas		
Electricity	Water	Cooling		
You are out of work	Spouse/Partner out of work	Substance use of others		
Concerns with a family member	Do not have any of these problems			
Would you like to discuss this with someone?		Yes	No	Prefer not to answer
Current Providers				
Name	Phone (###-###-####)	Do you want them to be part of your Care Team?		
			Yes	No
Name	Phone (###-###-####)	Do you want them to be part of your Care Team?		
			Yes	No

Name	Phone (###-###-####)	Do you want them to be part of your Care Team?		
			Yes	No

Resources

Community Resources and Services Being Utilized

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

Needed Community Resources and Services

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

Disaster Plan						
Disaster Preparedness Plan						
Child Health & Well-Being						
Birth History						
Birth weight (in pounds)						Don't know
Delivery Method				Vaginal	C-Section	Don't know
Baby was born				At Term	Early	Don't know
Indicate at how many weeks gestation if the baby was born early. Otherwise						Don't know
Did the baby have any problems right after birth				Yes	No	Don't know
Was there any illness or problem with the mom's pregnancy				Yes	No	Don't know
During the pregnancy did the mother smoke				Yes	No	Don't know
If yes, what did the mother smoke						Don't know
During the pregnancy did the mother drink alcohol				Yes	No	Don't know
If yes, when during the pregnancy did she drink						Don't know
During the pregnancy did the mother use drugs/medicine				Yes	No	Don't know
Did the baby go home with the mother from the hospital				Yes	No	Don't know
Health Behaviors						
How often can you/your child depend on having an adult to talk to						
Never	Rarely/ Almost	Less than half the time	More than half the time	Usally	Almost always	Always
If a problem or emergency arises, how often can you/your child depend on an adult to turn to for help and support						
Never	Rarely/ Almost Never	Less than half the time	More than half the time	Usally	Almost always	Always
In the past 6 months, have you/has your child ...						
… seen any non-violent crime in your/their neighborhood, such as someone selling drugs or stealing					Yes	No
… seen any violent crimes taking place in your/their neighborhood, such as someone being beaten up					Yes	No
… known someone other than yourself/themselves who was a victim of a violent crime in your/their neighborhood					Yes	No
… been a victim of a violent crime in your/their neighborhood					Yes	No
… been bullied at school (including cyberbullying) or in your/their neighborhood					Yes	No
… experienced on-line bullying or threats (cyber-bullying)					Yes	No
Caregiver						
Do you/Does your child have a caregiver that comes into the home, because of a health care problem, to provide you with assistance?					Yes	No
Is caregiver a relative, friend or from an agency?				Relative	Friend	Agency
Caregive/Agency Name						

Caregive/Agency phone number (###-###-####)				
Caregive/Agency Specialty				
How many hours per day/week does caregiver come into your home? (☐ per day, or ☐ per week)				
What items does your caregiver help with?				
Do you/Does your child need more help than you are receiving?			**Yes**	**No**
Please explain:				
ADL/IADL				
Please indicate your ability to do the activities in the table below.				
Bathing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Dressing				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Grooming				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Mouth care				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Toileting				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Transferring bed/chair				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Walking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Climbing Stairs				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Eating				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Shopping				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	
Cooking				**Receiving Help?**
Independent	**Need Help**	**Dependent**	**Cannot Do**	

Sleep				
On average how many hours of sleep do you get in a 24 hour period				
Do you feel your sleep is restful?			Yes	No
Employment				
What is your current type of employment?				
Employed-Full time	Employed-Part time	Not employed, but seeking employment		
Not employed, not seeking employment	Not in labor force (e.g. retired, disabled, homemaker, student, volunteer	Prefer not to answer		
If not employed (circle all that apply):				
I am in the the process of seeking benefits or I don't want to risk losing my benefits	I worry that my symptoms will interfere with my work	I'm not sure how to go about getting a job		
Not applicable	Other	Prefer not to answer		
If employed, how many hours do you work per week				
Development				
Are you concerned about your/your child's physical development			Yes	No
Explain:				
Are you concerned about your/your child's mental or emotional development			Yes	No
Explain:				
Are you/Is your child having problems with behavior in school?			Yes	No
Explain:				
Have you/Has your child failed or repeated a grade?			Yes	No
Explain:				
Are you/Is your child having academic problems in school?			Yes	No
Explain:				
Are you/Is your child in special resource classes/special education?			Yes	No
Explain:				
Durable Medical Equipment				
Air-fluidized beds and other support surfaces	Have	Want	Wish to discuss	Don't Need
Bar in toilet/shower	Have	Want	Wish to discuss	Don't Need
Blood sugar (glucose) test strips	Have	Want	Wish to discuss	Don't Need
Blood sugar monitors	Have	Want	Wish to discuss	Don't Need

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

Legal			
Do you/Does your child have an advance directive and/or living will?	Yes	No	Don't Know
Do you/Does your child have a copy of your advance directive and/or living will to put in your record?		Yes	No
Do you/Does your child have a psychiatric advance directive?	Yes	No	Don't Know
Do you/Does your child have a copy of your advance directive and/or living will to put in your record?		Yes	No
Have you/Has your child given Power of Attorney (POA) to someone?		Yes	No
If yes, who?			
Do you/Does your child have a copy of your POA to put in your record?		Yes	No
Safety/Injuries			
Have you/Has your child ever been physically, sexually, or emotionally abused		Yes	No
Have you/Has your child ever been in foster care, group home(s), or been homeless		Yes	No
Have you/Has your child ever been in jail or in a detention center		Yes	No
In the past 6 months, how many times have you/has your child:			
Been out of your/their parent's or caregiver's control so that the police needed to get involved	None	1 time	More than 1 time
Purposefully damaged or destroyed (other than fire) property that did not belong to you/them	None	1 time	More than 1 time
Taken something from a store without paying for it	None	1 time	More than 1 time
Hit someone or been in a physical fight	None	1 time	More than 1 time
Gotten a ticket or citation for a traffic violation (driving too fast, driving through a red light, etc.)	None	1 time	More than 1 time
Do you/Does your child have a gun/firearm in the home		Yes	No
If yes, is it unloaded and locked up		Yes	No
Client Concerns			
What are your/your child's future plans for additional schooling, having a family, and career goals?			
Clinical Summary			
Allergies			
Medication allergies		Yes	No
If yes, what are they?			
Food allergies		Yes	No
If yes, what are they?			
Environmental allergies (hay fever, dust, etc.)		Yes	No
If yes, what are they?			

Pharmacy Name
Pharmacy Location
Pharmacy phone number (###-###-####)

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

Previous medications: Only list atypical anti-psychotics from the following: Risperdal (Risperidone),					
Medication	**Dose (if known)**	**How often do you take them?**	**Start Date**	**End Date**	**What are they for?**

Now or in the past 6 months, have you taken any prescribed medications for emotional or behavioral symptoms?	**Yes**	**No**
Have the medications helped you feel better?	**Yes**	**No**
In what ways have they helped?		
In the past 6 months have you had any bad side effects from these medications?	**Yes**	**No**
What were the bad side effects?		

Over the counter medications, herbs, vitamins, or supplements:				
Medication, herb, vitamin, or supplement	**Dose (if known)**	**How often do you take them?**	**Start Date**	**What are they for?**

Do you have trouble taking medications as prescribed?	Do not have to take medicine	Always take as prescribed	Sometimes take as prescribed	Seldom take as prescribed
Do you want help with this?			Yes	No
Other treatments that you are receiving (counseling, psychotherapy, OT, PT, chiropractor, acupuncture, traditional healing, other):				

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

Convulsions or neurological problems	Past	Present	Yes	A little	No	Yes	No
Depression	Past	Present	Yes	A little	No	Yes	No
Developmental/ Intellectual Disability	Past	Present	Yes	A little	No	Yes	No
Diabetes	Past	Present	Yes	A little	No	Yes	No
Dizziness	Past	Present	Yes	A little	No	Yes	No
Drug abuse	Past	Present	Yes	A little	No	Yes	No
Eating disorder	Past	Present	Yes	A little	No	Yes	No
Fainting	Past	Present	Yes	A little	No	Yes	No
Frequent abdominal pain	Past	Present	Yes	A little	No	Yes	No
Frequent ear infections	Past	Present	Yes	A little	No	Yes	No
Frequent headaches	Past	Present	Yes	A little	No	Yes	No
Gallbladder disease	Past	Present	Yes	A little	No	Yes	No
Glaucoma	Past	Present	Yes	A little	No	Yes	No
Gout	Past	Present	Yes	A little	No	Yes	No
Hallucinations	Past	Present	Yes	A little	No	Yes	No
Headache	Past	Present	Yes	A little	No	Yes	No
Hearing problems	Past	Present	Yes	A little	No	Yes	No
Hepatitis (A, B, C)	Past	Present	Yes	A little	No	Yes	No
Hernia	Past	Present	Yes	A little	No	Yes	No
Herpes	Past	Present	Yes	A little	No	Yes	No
High blood pressure	Past	Present	Yes	A little	No	Yes	No
Kidney disease	Past	Present	Yes	A little	No	Yes	No
Liver disease	Past	Present	Yes	A little	No	Yes	No
Low blood pressure	Past	Present	Yes	A little	No	Yes	No
Lung disease	Past	Present	Yes	A little	No	Yes	No
Measles	Past	Present	Yes	A little	No	Yes	No
Mumps	Past	Present	Yes	A little	No	Yes	No
Mental illness	Past	Present	Yes	A little	No	Yes	No
Mental retardation	Past	Present	Yes	A little	No	Yes	No
Nasal allergies	Past	Present	Yes	A little	No	Yes	No
Neurological disorder	Past	Present	Yes	A little	No	Yes	No
Obesity or been overweight	Past	Present	Yes	A little	No	Yes	No
Pacemaker	Past	Present	Yes	A little	No	Yes	No
Physical abuse	Past	Present	Yes	A little	No	Yes	No
Pneumonia	Past	Present	Yes	A little	No	Yes	No
Polio	Past	Present	Yes	A little	No	Yes	No
Problems with eyes or vision	Past	Present	Yes	A little	No	Yes	No
Legal Blindness	Past	Present	Yes	A little	No	Yes	No

Problems with ears or hearing	Past	Present	Yes	A little	No	Yes	No
Rheumatic fever	Past	Present	Yes	A little	No	Yes	No
Sexual abuse	Past	Present	Yes	A little	No	Yes	No
Sexually transmitted disease	Past	Present	Yes	A little	No	Yes	No
Shingles	Past	Present	Yes	A little	No	Yes	No
Sleep problems	Past	Present	Yes	A little	No	Yes	No
Stomach problems	Past	Present	Yes	A little	No	Yes	No
Stroke	Past	Present	Yes	A little	No	Yes	No
Suicide attempt	Past	Present	Yes	A little	No	Yes	No
Thyroid or other endocrine problems	Past	Present	Yes	A little	No	Yes	No
Tobacco use	Past	Present	Yes	A little	No	Yes	No
Tuberculosis	Past	Present	Yes	A little	No	Yes	No
Ulcers	Past	Present	Yes	A little	No	Yes	No
Urinary problems/incontinence/wetting self	Past	Present	Yes	A little	No	Yes	No
Use of alcohol or drugs	Past	Present	Yes	A little	No	Yes	No
Violent or aggressive behaviors	Past	Present	Yes	A little	No	Yes	No
Wandering or running away	Past	Present	Yes	A little	No	Yes	No
Condition/Behavior-Do you have or have you ever had: (circle Past and Present if ongoing)							
Problems with teeth						Yes	No
Problems with gums						Yes	No
Difficulty chewing						Yes	No
Difficulty swallowing						Yes	No
Appetite change last six months						Yes	No
Weight loss						Yes	No
Weight gain						Yes	No
Women's Health							
Period started at age							
Number of pregnancies							
Number of live births							
Number of miscarriages							
Do you have or have you ever had:							
Birth Control						Yes	No
If yes, which one							
Hysterectomy						Yes	No
PAP						Yes	No
If yes, indicated date of your PAP				_ _/_ _/_ _ _ _		Don't know	

Mammogram			Yes	No
If yes, indicated date of mammogram	_ _/_ _/_ _ _ _		Don't know	
Men's Health				
Penis discharge			Yes	No
Sore on penis			Yes	No
Erectile dysfunction			Yes	No
Testicular lump			Yes	No
Vasectomy			Yes	No
PSA	_ _/_ _/_ _ _ _		Yes	No
Prostrate problems			Yes	No
Prostate exam	_ _/_ _/_ _ _ _		Yes	No

E.R. Visits	
Date	**Reason**

Surgeries	
Date	**Reason**

Substance Abuse Treatments	
Date	**Reason**

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

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

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

Hospitalizations	
Date	**Reason**

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