Springfield Wellness Clinic

(This form can be filled out online and printed at home)

Patient Sticker

Date:_____

Patient Name:_____ Date of Birth:_____
Last First MI

Gender: ☐ Male ☐ Female Age: _____ Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Cell #:_____ Work Telephone:_____ ext.____

Please indicate if we may leave a message for you at: ☐ Home ☐ Cell ☐ Work

E-Mail Address: _____

Race (optional): ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ I prefer not to answer

Ethnicity (optional): ☐ Not of Hispanic/Latino Origin ☐ Hispanic/Latino Origin ☐ I prefer not to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

In an emergency, notify:_____ Phone#:_____ Relationship:_____

List your preferred pharmacy name**:**_____ Location:_____

Name of your Primary Care Provider:_____ or ☐ I don't have a PCP

Please indicate if you are a: ☐ City of Springfield Employee ☐ Dependent of an Employee ☐ Retiree with City

If Patient is a minor:

Mother's Name:_____ Date of Birth:_____ Phone#:_____
Home Address: ☐ Same as minor Child_____

Fathers Name:_____ Date of Birth:_____ Phone#:_____
Home Address: ☐ Same as minor Child_____

INSURANCE INFORMATION

Primary Insurance:

Name of Insurance:_____ ID No:_____ Group No:_____
Name of Policyholder: ☐ Same as Patient ☐ Other:_____
If Other, please list the date of birth of the policyholder:_____

Secondary Insurance:

Name of Insurance:_____ ID No:_____ Group No.:_____
Name of Policyholder: ☐ Same as Patient ☐ Other:_____
If Other, please list the date of birth of the policyholder:_____

Springfield Wellness Clinic
Cascade Health Solutions
Health History Questionnaire

Patient Sticker

Name:_____ **Date of Birth:**_____ **Date of Exam:**_____
Reason for seeking medical attention:_____
Other doctors involved in my care:_____
Personal Medical History: Have you ever been diagnosed with the following? (Please check)

Heart Disease	Lung Disease	Musculoskeletal	General
☐ Murmur	☐ Emphysema	☐ Gout	☐ Paralysis
☐ Angina	☐ Asthma	☐ Rheumatoid Arthritis	☐ Bleeding Disorder
☐ Congestive Heart Failure	☐ Chronic Bronchitis	☐ Muscle/Joint Disorder	☐ Glaucoma
☐ Rheumatic Fever	☐ Pneumonia	**Kidney/Bladder**	☐ Cancer
☐ Bypass Surgery	☐ Cancer	☐ Stones	☐ Anxiety
☐ Valve Replacement	☐ Asbestosis	☐ Prostate Disorder	☐ Depression
☐ Heart Infection	**Gastrointestinal**	☐ Incontinence	☐ Mental Illness
☐ Irregular Heartbeat	☐ Polyps	☐ Infection	☐ Alcoholism
☐ Heart Attack	☐ Gallstones	**Skin**	☐ Drug Abuse
Infectious Disease	☐ Hiatal hernia	☐ Disorder	☐ Blood Transfusion
☐ AIDS or HIV Positive	☐ Hepatitis	**General**	☐ Congenital Disorder
☐ TB	☐ Hemorrhoids	☐ High Blood Pressure	
☐ STD	☐ Irritable Bowel Synd.	☐ Diabetes	
Gynecological	☐ Spastic Colon	☐ High Cholesterol	
☐ Abnormal Pap	☐ Colitis	☐ Migraines	
☐ Cancer	☐ Diverticulosis	☐ Anemia	
☐ Endometriosis	☐ Cancer	☐ Thyroid Problem	
☐ Fibroids	☐ Bleeding	☐ Seasonal Allergies	
☐ Cysts	☐ Ulcers	☐ Stroke	
☐ Irregular Bleeding	☐ UlcersIrregular Bleeding	☐ Seizure Disorder	

Hospitalizations, Operations, Injuries, and Serious Illnesses and Accidents

List since previous physical, or if not previously listed. Omit pregnancies.

	Year		Year
1.		3.	
2.		4.	

Medications (include non-prescription drugs, herbs & vitamins)

Current Medications	Dosage	Current Medications	Dosage
1.		6.	
2.		7.	
3.		8	
4.		9.	
5.		10.	

Allergies (include adverse reactions to medicine, food, materials, etc.)

Allergy	Reaction	Allergy	Reaction
1.		3.	
2.		4.	

Family History	Father	Mother	Father's Grandmother/Grandfather		Mother's Grandmother/Grandfather		Siblings	Children
	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐

Male Health History

☐ History of sexually transmitted disease? _____ ☐ Discharge from penis?
☐ Testicular pain? ☐ Lumps in testicles or scrotum? ☐ Decrease in testicular size? ☐ Decrease in sexual desire?
☐ Decreased ability in achieving erection? Do you have concerns about your sex life? ☐ No ☐ Yes

Female Health History

Age of onset of menstrual periods : _____Date of last period:_____ Date of menopause:_____.
Date of last PAP: _____Have you had abnormal PAPS?☐ No☐ Yes Date: _____ .
Do you ever bleed between periods?☐ No ☐Yes Have you had vaginal bleeding since menopause? ☐No☐ Yes
Heavy vaginal discharge?☐ No☐ Yes Menstrual Pain? ☐No☐ Yes Hot flashes? ☐No☐ Yes
History of sexually transmitted disease?☐ No☐ Yes ☐Decrease/increase in sexual desire?
Do you have a history of?☐ Endometriosis ☐Ovarian growths ☐DES exposure? ☐Infertility ☐Fibroids?
Number of pregnancies _____Live births _____ miscarriage(s) _____ Current contraception being used?

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow Occupation:

Are you currently or have you ever been in a relationship where you were hurt, threatened, or made to feel afraid?☐Yes ☐No

Living Situation: ☐ Alone ☐ Roommate ☐ Spouse ☐ Parents ☐ Significant Other ☐ With Children

Preventive Health Status

Date of last physical exam:		Date of last eye exam:	
Do you exercise regularly? ☐ Yes ☐ No	Type:	How Often?	
Do you follow a special diet? ☐ Yes ☐ No	Describe:		
Do you use tobacco? ☐ Yes ☐ No	How much/how long?	Quit/When?	
Do you drink alcohol? ☐ Yes ☐ No	How much per week?	Quit/When?	
Do you drink caffeine? ☐ Yes ☐ No	How much per day?	Quit/When?	
Have you used illicit drugs? ☐ Yes ☐ No	Which ones?	Quit/When?	
Do you use marijuana? ☐ Yes ☐ No			

Springfield Wellness Clinic
In partnership with
Cascade Health Solutions

204 Fifth Street Springfield OR 97477

Patient Sticker

Patient Name:_____ Exam Date:_____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns. During the past two weeks, have you often been bothered by any of the following problems?

Little interest or pleasure in doing things? ☐ Yes ☐ No

Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No

If you answered YES to either of the above questions please turn this over and answer the additional questions.

If you answered NO to both questions you are done with this questionnaire.

If you answered "Yes" to either question on the front page - please answer all questions below.

During the past two weeks, how often have you been bothered by any of the following problems? Place an **"X"** in the box beneath the answer that best describes how you have been feeling.	**(0) Not At All**	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, irritable or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating	☐	☐	☐	☐
6. Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, like reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

10. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

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

Springfield Wellness Clinic
204 Fifth Street
Springfield, OR 97477

Patient Sticker

CONDITIONS FOR RECEIVING SERVICES

MEDICAL CONSENT: I voluntarily request and consent to the medical care provided by Cascade Health Solutions. I understand my medical care and treatment is under the management of the attending medical service provider. This organization assumes no liability for any act or omission in following the instruction(s) of said provider. The undersigned consents to any diagnostic imaging and/or laboratory procedures, medical treatments, or other services rendered under the general and/or special instruction of the provider. The attending medical provider will explain the need for such treatments, procedures and/or services to allow the patient to make an informed decision regarding care. I understand that if I need specific services not provided by the agency, such services must be arranged by the patient, or legal representative. The agency shall in no way be responsible to provide the same.

CONSENT TO RELEASE HEALTH INFORMATION: I consent to allow Cascade Health Solutions to furnish any part of my medical record to any person or company, agency, or other authorized party responsible for all or part of my healthcare charges. By giving consent, I understand the requestor may have access to otherwise confidential information contained within my medical record. If I choose to not release my health information, I understand and agree I will pay for all my healthcare charges in the event payment is denied.

SPECIAL CONSENT: I understand my medical record may contain information specific to drug/alcohol abuse and/or addiction, and/or psychiatric conditions, and/or HIV testing, and/or HIV positive diagnosis, and/or genetic testing. Such diagnosis and treatment information may not be released without my specific consent. I consent to allow such information to be given to any person, corporation, agency, or other authorized party responsible for all or part of my healthcare charges. I can withdraw my consent at any time. My consent is valid for this service event only and when the billing process is complete, it lapses.

CONSENT FOR REVIEW OF MEDICAL RECORD BY FEDERAL/STATE AGENCIES AND OTHER AUTHORIZED AUDITING AND REVIEW AGENCIES: I understand there are federal/state and other agencies who are required to review, and on occasion, copy parts of my medical record for the purpose of assuring an acceptable standard of medical care and charges for my healthcare services are correct as stated. I consent to review of my medical record for these purposes alone.

IF THE PATIENT IS A MINOR OR LEGALLY INCOMPETENT TO SIGN FOR HIS/HER OWN MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE FOR ANY OF THE ABOVE CONSENTS.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby obligates him/herself to pay the account of Cascade Health Solutions in accordance with the rates and terms of the organization. Should the account be referred to an attorney or collection agency for collection and/or suit, the undersigned shall pay reasonable attorney's fees and collection expense.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Cascade Health Solutions and/or its agents of the group or personal benefits or any other insurance benefits otherwise payable to me, for this period of service. I understand I am financially responsible to Cascade Health Solutions for charges not covered by this assignment. A photocopy of this authorization shall be considered as effective and valid as the original.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release sufficient information regarding my diagnosis or treatment for billing purposes. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand I am financially responsible to Cascade Health Solutions for charges not covered by this assignment.

ACKNOWLEDGEMENT OF EPRESCRIBING

I agree that the Springfield Wellness Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices of Cascade Health Solutions describes how my health information may be used and shared, and how I may obtain access to my health information. I understand that the organization has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Privacy Officer at 541-228-3056.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF GENETIC RESEARCH OPT-OUT NOTIFICATION AND OPT-OUT STATEMENT

I have received a copy of CHS's Genetic Research Opt-out notification and Opt-out Statement form that allows me to opt out of future anonymous or coded genetic research. I understand that CHS has the right to change this Notice at any time. I may obtain a current copy of the Genetic Research Opt-out notification and Opt-out statement form by contacting the Privacy Officer, at 541-228-3056.

By signing below, I acknowledge that I have been provided a copy of the Genetic Research Opt-out notification and Opt-out statement form.

Initials_____

A COPY OF THIS "CONDITIONS FOR RECEIVING SERVICES" FORM IS AVAILABLE UPON REQUEST.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____ _____

DATE PATIENT

_____

PATIENT'S AGENT OR REPRESENTATIVE

_____ _____

WITNESS RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and/or Genetic Research Opt-out notification and Opt-out Statement form, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

Revised November 23, 2012