

Drug/Medication Allergies: Please list all prescription or over the counter medication allergies. Also state the type of reaction (For example, rash or hives) State none, if none.

Personal Current Medical History: Please check all that apply to you.

- | | |
|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pancreas Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer, what kind |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> High Cholesterol |

Family Medical History (blood relatives only)

If your Mother, Father, or Siblings have any of the following:

	<u>Mother</u>	<u>Father</u>	<u>Siblings</u>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Surgeries

Have you ever had surgery? Yes No If yes, please list date(s) and what kind.

Social History:

Do you drink alcohol? Yes No If yes, how much per day, and how long?

Do you use caffeine? Yes No If yes, how much per day?

Do you use recreational drugs? Yes No If yes, type/amount and how long?

Do you smoke cigarettes? Yes No If yes, how many a day and how long?

Do you use smokeless tobacco? Yes No If yes, how much and how long?

Medical Information Release

DO NOT release any information to anyone except me

You have my permission to disclose information to the following person(s)

Patient/Guardian Signature: _____

Date: _____

Western Kentucky Medical Group
116 Main St Cadiz KY 42211
Phone: (270)350-4504 Fax: (270)350-4590
Authorization for Use of Protected Health Information

Patient Name: _____
Date of Birth: _____ SS# _____

I authorize Western Kentucky Medical Group

to:

RELEASE Medical Records to: _____ OBTAIN Medical Records from

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of Request

Continue Care Insurance Claim Other:

Attorney Personal Use _____

Information Requested

Entire Medical Record

I specifically authorize release of info pertaining to:

Other: _____

-HIV/AIDS -Alcohol/Drug Abuse Treatment

-Mental Health -Genetic Testing

Specific Date(s): _____

It is understood that my records may not be released to me at the same time as requested. You may revoke or terminate this authorization by contacting the medical record department. I understand, however, that revocation will not apply to information that has already been released to this authorization.

I understand that if the person(s) or entity that receives this information is not a health care provider or health plan covered by the Health Insurance Portability and Accountability Act of 1966 (HIPPA), the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Trigg County Medical Clinic, its employees and Providers, from all liability arising from this disclosure of health.

I understand that I am entitled to ONE FREE COPY of my medical records during my lifetime. Any additional copies sent for any reason are subject to a copy fee of \$15

Patient Signature/Legal Representative

Relationship to patient

Date

Witness Signature

Date

Patient Name: _____ DOB: _____

FINANCIAL RESPONSIBILITY:

I (the patient) hereby agree to pay for all services rendered at Trigg County Medical Clinic. I am aware that if I do not have insurance, I will be responsible for any services rendered. I will pay in full any balance due to Trigg County Medical Clinic.

CONSENT FOR TREATMENT:

I (the patient) hereby authorize the doctor/nurse practitioner at Trigg County Medical Clinic to administer local anesthetics and/or medications necessary to perform simple surgical procedures and diagnostic procedures, as maybe deemed advisable in diagnostic and treatment of the patient.

CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION:

I (the patient), hereby grant authorization to release from Trigg County Medical Clinic such information, as may be necessary for the completion of my medical claims. Also, by signing, I realize that I am authorizing Trigg County Medical Clinic to make referrals and distribute any necessary information regarding my condition. In addition, I am entitled to one free copy of my own medical records upon request.

CONTROLLED SUBSTANCE AGREEMENT/ KASPER REPORTS:

I (the patient) understand that while receiving controlled substances from Trigg County Medical Clinic, I am not allowed to receive controlled substance prescriptions from any other doctors. I also understand and consent, that I will be asked to give random urine drug screens at any time while being prescribed these medications. I also authorize the doctor/nurse practitioner at Trigg County Medical Clinic to run KASPER reports when prescriber controlled substances.

ADVANCED DIRECTED (check below)

I (the patient), have a living will.

A copy of my living will is on file at _____

I do not have an Advanced Directive, but have received information about Advanced Directives.

SIGNATURE OF PATIENT:

I (the patient) have read the above statements and give my consent

X _____ Date: _____

Current Psych Symptoms (Check for each symptom present): Depressed mood Racing thoughts Excessive worry Unable to enjoy activities Impulsivity Anxiety attacks Sleep pattern disturbance Increase risky behavior Avoidance Loss of interest Increased libido Hallucinations Concentration/forgetfulness Decrease need for sleep Suspiciousness Change in appetite Excessive energy Excessive guilt Increased irritability Fatigue Crying spells Decreased libido

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?

Psychiatric History: Have you ever been diagnosed with a mental health disorder in the past? Have you ever been treated for your mental health in the past? Yes No (If you checked yes please explain the treatment received and diagnosis)

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? _____
What is your highest educational level or degree attained? _____

Legal History: Have you ever been arrested? (If yes, please explain)

Do you have any pending legal problems? (If yes, please explain)

Occupational History: Are you currently: Working Student Unemployed Disabled Retired

What is your goal for mental health treatment?

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =
Total score _____

If you checked any problems, how difficult have they 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
 GAD-7 total score for the seven items ranges from 0 to 21.

- 0–4: minimal anxiety
- 5–9: mild anxiety
- 10–14: moderate anxiety
- 15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____

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, please refer to accompanying scoring card). TOTAL: _____

10. If you checked off any problems, 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 _____