Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

NEW PATIENT REGISTRATION

(Please write clearly)

DEMOGRAPHICS:

Patient Full Name: _____ DOB: _____
(Last Name) (First Name) (Middle Name)

Other Names Used: _____

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ Email Address: _____

Preferred Contact Phone Number: ☐ Cell ☐ Home ☐ Work

How may we contact you? ☐ Text ☐ Email ☐ Phone ☐ Postal Mail

May we leave confidential voicemail messages on your phone? ☐ Yes ☐ No

SSN: _____ (For your identity privacy at NUNM and is used solely for that purpose)

The following information you provide us helps to serve you and members of the community.

What was your assigned sex at birth? ☐ Male ☐ Female Other (specify) _____

What gender do you identify as? ☐ Male ☐ Female Other (specify) _____

What pronoun do you use? ☐ He/Him/His ☐ She/Her/Hers Other (specify) _____

Interpreter needed? ☐ Yes ☐ No Primary Language: _____

Homeless Status? ☐ Not Homeless ☐ Homeless ☐ At Risk ☐ Transitional Housing ☐ Living in Shelter

Seasonal or Migrant Worker? ☐ Seasonal ☐ Migrant ☐ Neither

Ethnic Group (Select One): ☐ Hispanic ☐ Non-Hispanic ☐ Other _____

Race (Select all that apply): ☐ Asian ☐ Black ☐ White ☐ Alaskan Native ☐ Pacific Islander
☐ American Indian ☐ Other _____

Are you a US Veteran? ☐ Yes ☐ No

Occupation: _____Hours per Week: _____ Employer: _____

Employment Status (Check all that apply): ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Seasonal
☐ Self-Employed ☐ Student (Full Time) ☐ Student (Part Time) ☐ NUNM Student ☐ NUNM Staff

Date Completed: _____

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NEW PATIENT REGISTRATION (CONTINUED)

PRIMARY CARE PROVIDER: *(Please select one of the following):*

☐ I wish to establish Primary Care with NUNM Health Centers.

☐ I see NUNM for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: _____

At (Clinic Name): _____

☐ I do not have a Primary Care Physician and do not wish to establish Primary Care with NUNM at this time.

**Please Note: Some services provided by NUNM require that the patient be established with a PCP. These services include any specialty service, including, but not limited to cancer care, IV therapy, physical medicine, and homeopathy.*

OTHER PROVIDERS (SPECIALISTS):

_____

_____

EMERGENCY CONTACT: *(The person NUNM will call in the event of an emergency)*

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? ☐ Yes ☐ No

GUARANTOR: *(The person who is financially responsible for the account):*

Name: _____ Relationship to the patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Gender: ☐ M ☐ F ☐ Other DOB: _____

Guarantor Primary Language: _____ Phone: _____

INSURANCE: *(Please provide your insurance information below)*

The NUNM Health Centers Billing Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit. **Please be prepared to present your insurance card at check-in for each visit.**

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB:_____

Date Completed: _____

MRN: _____

DOB: _____

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Member ID#: _____ Group #: _____ Subscriber ID #: _____

Although NUNM is not contracted with Medicare, it is our policy to collect all coverage information

Do you have Medicare? □ Yes □ No If "yes", is it your primary insurance? □ Yes □ No

Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C)

Subscriber ID #_____ Effective Date (if known): _____

OPTIONAL: *I authorize the following individual(s) to arrange appointments at NUNM on my behalf*:

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

AUTHORIZATION: *I certify the above information is true and correct to the best of my knowledge.*

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Thank you for completing this form. Please also take a moment to acknowledge your rights and responsibilities as a patient of NUNM health centers.

Patient Rights & Responsibilities

The full documentation of NUNM's Patient Rights and Responsibilities is available for review in the health centers lobby or by request to the front desk. You may also request a copy for your records.

AUTHORIZATION: *I certify that I have reviewed and understand my patient rights and responsibilities.*

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Date Completed: _____

MRN: _____

DOB: _____

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NATUROPATHIC MEDICINE, CLASSICAL CHINESE MEDICINE, AND NUTRITION CONSENT TO ESTABLISH CARE

Informed consent is a process, not a form, and involves an ongoing, interactive dialog between you and your provider. The process of informed consent occurs when communication between you and your provider results in your authorization or agreement to undergo a specific medical intervention.

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of the National University of Natural Medicine (NUNM) Health Centers. I understand that patient care is directed by licensed health care providers who are employees of NUNM. I consent to services rendered to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I recognize that NUNM is a teaching institution. I agree that persons who are students and resident physicians will participate in my care as part of the educational programs of the institution. I hereby request and consent to examination and treatment with the providers, students, and affiliated providers at NUNM Health Centers.

I understand I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/or students:

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that evaluation and treatment may include, but is not limited to:

- Common diagnostic procedures (including but not limited to physical examination, laboratory testing of blood and other bodily fluids, electrocardiogram, lung function testing, ultrasound, and referrals for external diagnostic procedures).
- Soft tissue treatment (including but not limited to massage, neuro-muscular technique, and muscle energy technique) and naturopathic osseous manipulation of the spine and extremities (see Physical Medicine treatment section below for detail).
- Dietary and therapeutic nutrition recommendations and counseling (including but not limited to the use of foods, individualized diet plans, nutritional supplements, and parenteral (intravenous or intramuscular) vitamin injections (see separate Parental Injection consent below).
- Trigger point injection/Prolotherapy with or without vitamin substances.
- Natural substance prescriptions (including but not limited to plant/herbal, mineral or animal-based substances in full strength or highly diluted/homeopathic). Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- Counseling (including but not limited to mindfulness techniques, behavioral change, stress management techniques, and tobacco/substance use cessation).

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- Over-the-counter and prescription medications (including only those medications listed on the Oregon Board of Naturopathic Medicine formulary).

- Hydrotherapy procedures (including but not limited to alternating hot and cold applications, baths, sauna, ice, towels and/or sheets , electrical stimulation, ultrasound and diathermy) and other therapies. Possible risks and complications associated with these procedures may include:
  - Mild skin burns or irritation
  - Skin rash
  - Temporary decrease in blood pressure
  - Overheating
  - Dizziness

- Classical Chinese medicine procedures including, but not limited to acupuncture, moxibustion, cupping, electro-acupuncture, herbology, and massage. Possible risks and complications associated with these procedures may include:
  - Slight burns
  - Nausea
  - Infections and blisters
  - Fainting
  - Scarring
  - Bruising
  - Bleeding
  - Tingling/soreness near needling sites that may last a few days

- Physical medicine treatments including examination, diagnostic procedures, manipulation and/or mobilization of the neck, spine, and extremities involving movement of the joints and soft tissues, and soft tissue therapies (specifically: manual soft tissue therapies, instrument-assisted soft tissue mobilization (IASTM), percussion/vibration therapy and therapeutic tape procedure). Physical therapy, including exercise, electrical stimulation, hot/cold therapies, ultrasound, diathermy, TENS units, low-level laser therapy, traction, and other therapeutic modalities recommended for my condition may also be used. Possible risks and complications associated with these procedures may include:
  - Soreness
  - Muscle spasms
  - Temporary increase in symptoms
  - Sprains and strains
  - Dizziness
  - Fractures/joint injury
  - Mild to moderate bruising
  - Physical Therapy burns (rare)
  - Stroke (has been rarely reported to occur specifically from neck manipulation)

- Parenteral Injection (Intravenous [IV] and Intramuscular) Therapy treatments including drips, pushes, and IV chelation (heavy metal detoxification). This treatment involves inserting a needle and injecting a standardized formula into veins or muscles. Possible risks and complications associated with these procedures may include:
  - Pain, bruising, or infection at injection site
  - Inflammation of vein used for infusion (phlebitis)
  - Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death

  Alternatives to IV Therapy include:
  - Oral supplementation
  - Lifestyle and dietary change

Date Completed: _____

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DOB: _____

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INFORMED CONSENT AND REQUEST FOR CARE (CONTINUED)

I understand that some medicines, supplements and procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider or student so that my treatment plan may be re-evaluated.
*Please note: There are additional consent forms for Parenteral injections or chelation therapy (IV Therapy), minor surgery, hormone treatments and other special procedures or services.

I have fully read and understand the above and hereby consent to services.

Signature of Patient Date

Signature of Parent/Guardian (if Patient is under 15) Date

Date Completed: _____

MRN: _____

DOB: _____

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FINANCIAL POLICY

At NUNM our policy is to collect payment for all services rendered at the time of service. Patients who are not able to pay or who have not made arrangements with our billing office may be required to reschedule their appointment. Patients may also receive a bill for additional services rendered, such as in-house labs and procedures ordered during an office visit, if the insurance company adjusts the bill, or if new information is acquired bringing about new charges. These bills are non-negotiable.

FOR ALL PATIENTS:

- There will be a flat fee of $20 for any appointment that is either missed or not canceled within 24 hours of the appointment time.
- You acknowledge that you are financially responsible for all charges. Any account over 120 days old will be sent to collections. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. You hereby authorize the NUNM Health Centers to release information necessary to secure payment.
- You are responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including Medicinary, lab work, and tests, as well as any physician ordered add-on lab work and tests.
- Refund Policy: We will issue a refund of any credit on an account 30 days from the issue of the credit to the account. Refunds are issued by check and mailed to the address on the guarantor account.

TIME OF SERVICE AND OTHER DISCOUNTS:

- If you apply and qualify for any discounts, you are responsible for providing accurate information for all required documentation within 30 days.
- As a courtesy of paying in full at the time of service, you will receive medical services at a discounted rate. If you do not pay at the time of service your account will not reflect a time of service discount.
- Discounts through our Compassionate Care program may be extended to you based upon the gross annual income information you provide.

IF YOU ARE INSURED:

- You authorize release of information in your medical history to your insurance carrier and assign all benefits for unpaid services to the NUNM Health Centers. This release applies to support of the insurance billing process only.
- The pre-verification by NUNM of your health insurance is used to determine if there is coverage for services through your insurance and is NOT a guarantee of payment by your insurance.
- You are responsible for providing all accurate and thorough documentation required to verify your insurance coverage and / or bill your insurance carrier.
- You understand that the NUNM Health Centers can require proof of insurance at any time and that your insurance may need to be re-verified for specific coverage details as often as every 6 months, if there is a denial of a claim, or if you have a change in coverage.
- You are responsible for full payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by your insurance carrier at the time of service.
- You are responsible for payment even if your insurance company makes a determination that the care received was not medically necessary.

Continued on backside

Date Completed: _____

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- You may forfeit the privilege of billing your insurance carrier if you do not comply with any of your financial responsibilities or documentation requirements.
- You understand that NUNM Health Centers will not bill motor vehicle insurance.

MINORS SEEKING TREATMENT WITHOUT A PARENT/GUARDIAN (AGES 15-17):

I, _____, certify that I am _____ years old. I am seeking outpatient health services from the National University of Natural Medicine (NUNM). I have been fully informed of the services to be rendered and consent to those services.

Payment Method – Choose One and Initial

1. _____ I agree to allow NUNM to notify my parent(s)' to the extent necessary to obtain insurance coverage for the services provided:

   My Insurance Information is as follows:

   Insurance Company _____

   Policy # _____

   My parent(s)' mailing address and phone number are as follows:

   Phone: _____

   Address: _____

   _____

2. _____ I do NOT want NUNM to notify my parent(s)' regarding any of these services unless required by (initial if yes) law to do so. I do not wish that NUNM obtain my parent(s)' consent to bill insurance. I fully understand that NUNM requires me to pay for all services in advance and that my failure to do so may result in termination of services. In the event that I am unable to pay for these services, NUNM may, at its sole discretion, terminate this relationship and refer me to appropriate health providers.

I have fully read, understand, and agree to these financial policies.

_____

Patient (15 years or older) Date

_____

Parent, Guardian, Responsible Party Date

Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my Protected Health Information by National University of Natural Medicine (NUNM) Health Centers for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- NUNM has posted their Notice of Privacy Practices on the NUNM Health Centers website, www.nunmhealthcenters.com, which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my Protected Health Information.
- I have the right to request an alternative to the standard method of communication of my Protected Health Information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the NUNM Health Centers at the following address: 3025 SW Corbett Avenue, Portland, Oregon 97201.
- I understand that while NUNM may honor these requests, they are not required by law to do so.
- NUNM is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN) which utilizes the *Care Everywhere* system. A current list of OCHIN participants is available at http://www.community-health.org/partners.html. As a business associate of NUNM Health Centers, OCHIN supplies information technology and related services to NUNM Health Centers and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by NUNM Health Centers with other OCHIN and *Care Everywhere* participants only when necessary for health care operations purposes of the organized health care arrangement.
- I am aware that NUNM reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that they maintain. In the event of amendments, NUNM will make available a revised Notice of Privacy Practice for my review.

I have fully read and understand the above agreements and authorizations.

_____

Patient (18 years or older) Date

_____

Parent, Guardian, Responsible Party Date

_____

Patient or Guardian Signature Date

Date Completed: _____

MRN: _____

DOB: _____

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COMPASSIONATE CARE APPLICATION

Proof of income is required for completion. Requirements must be met in full for enrollment in our financial assistance program. You will be notified by an NUNM staff member regarding your application status.

1. **Patient:** _____ _____ _____
   First Name Last Name Date of Birth

2. **(For Oregon Residents) NUNM offers enrollment assistance for Oregon Health Plan (OHP)/ Oregon Medicaid.**
   Would you like an application assister to contact you to set up an enrollment appointment? □ Yes □ No

   _____ _____
   Phone Number Email address

3. **Relationship to the Federal Poverty Level:**

   *Household Income is the combined gross (pre-taxed) income of all the members of a tax household (all legally connected or related people sharing a household or residence) who are 15 years of age and older.

Total # of People in Household	Combined Gross Income of Everyone in Household	How Often Does the Household Receive this Amount? (Circle One)
	$	Weekly Bi-Weekly Monthly Yearly

4. **Documents To Support Income Claim**

   What type(s) of document(s) did you bring to prove your household income? _____

   □ I have forgotten my documents and acknowledge that I will be given a courtesy period of 30 days to provide my documents. After that time I will not be eligible for discounts until I provide documentation.

5. **Please check all that apply to you.**

   □ Federal Retiree or Federal Medicare Recipient □ Veteran □ 62 Years of Age of Older

6. **Discount Policy Acknowledgement**

   I understand that if I am eligible for a discount that it will be applied only at check-out.
   Discounts are not applied for individuals who request courtesy billing (to have a bill sent to their mailing address), or for patients who forget to pay after their appointment.
   I certify this information to be a true and accurate account of my household and financial status at this time.
   I have read and agree to the financial assistance application provisions.
   If indicated I consent to having an NUNM representative contact me for OHP enrollment.

_____ _____
Signature of Applicant **Date**

STAFF USE ONLY: **Circle the best discount option:** Tier 1, Tier 2, Tier 3 / Time of Service Only / Honored Citizen
FPL %_____ / **Initial when complete:** FPL Field _____ / Patient Tier Flag _____ / Scanned documents _____

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Date Completed: _____

MRN: _____

DOB: _____

INCOME VERIFICATION FORM

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.

☐ I currently am unemployed and have no source of income.

☐ I do not have easy access to my paycheck stubs or income statements.

☐ I am self-employed with various sources of income.

☐ I do not file taxes and do not have a tax return statement.

☐ I do work that pays in cash only.
What is / are the source(s) of your income: _____

☐ I have a different reason- Please explain: _____
_____
_____
_____

Applicants/recipients must read the following and sign below:

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs and is reassessed on an annual basis. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

_____ _____
Signature of Applicant Date

STAFF USE ONLY: **Circle the best discount option:** Tier 1, Tier 2, Tier 3 / Time of Service Only / Honored Citizen
FPL %_____ / **Initial when complete:** FPL Field _____ / Patient Tier Flag _____ / Scanned documents _____

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Date Completed: _____

MRN: _____

DOB: _____

ADOLESCENT (10-17 yrs) HEALTH HISTORY

_____ _____ _____ _____
Last Name First Name Middle Init Date of Birth

Form filled out by: ☐ Self ☐ Parent ☐ Other: _____

What is the reason(s) for your visit to our Health Center today?

Primary concern: _____

Secondary concern: _____

Additional concern: _____

Additional concern: _____

*Please note that we may not be able to address all of your concerns in a single visit. We will address concerns as visit time allows in order of medical priority. Follow-up visits may be needed to address additional concerns.

When did the problem(s) begin? _____

Have these conditions been treated another health care provider in the past? ☐ Yes ☐ No

If YES, How long ago?: _____

Provider?: _____

Where?: _____

Is the problem(s) the result of an automobile accident and/or a work injury? ☐ Yes ☐ No

If YES, specify which concern was related to this accident/injury: _____

Adolescent Questions:

Who lives in the home? : _____

Does anyone in your household smoke or do you spend time in any place where people smoke?	☐ Yes	☐ No
Do you always use a car seat or seatbelt?	☐ Yes	☐ No
Have you ever been tested for lead?	☐ Yes	☐ No
Do you have any concerns about your social skills?	☐ Yes	☐ No
Do you exhibit any behavioral problems?	☐ Yes	☐ No
Do you enjoy school?	☐ Yes	☐ No

What is your favorite subject at school? _____

Any challenges with school we should be aware of? _____

Any abuse at school or at home?	☐ Yes	☐ No
Are you having any problems with hearing?	☐ Yes	☐ No

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Date Completed: _____

MRN: _____

DOB: _____

Date of last hearing exam (if applicable)? _____

Are you having any sleeping problems? ☐ Yes ☐ No

How many times per day do you brush your teeth? : _____

Date of last dental exam (if applicable): _____

Date of last vision exam (if applicable): _____

Allergies: Do you have any allergies to the following? *(Please select all that apply)*

☐ Aspirin	☐ Bees	☐ Cats	☐ Codeine	☐ Contrast Dye	☐ Dogs
☐ Eggs	☐ Fish	☐ Latex	☐ Lidocaine	☐ Milk	☐ Mold
☐ Morphine	☐ NSAIDS	☐ Peanuts	☐ Penicillin	☐ Pollen	☐ Shellfish
☐ Soy	☐ Sulfa	☐ Sulfites	☐ Tetracycline	☐ Wheat	☐ Other: _____

Name of Medication/Supplement	Strength	Frequency Taken and Route (oral, topical, etc.)	How long have you been taking this?

Medical Conditions: Do you currently have or have a history of the following? *(Please select all that apply)*

☐ Adrenal Disorder	☐ Depression	☐ Inflammatory Bowel Disease
☐ Anemia	☐ Diabetes Mellitus	☐ Irritable Bowel Syndrome
☐ Anxiety	☐ Digestive Problem	☐ Kidney Disease
☐ Arthritis/Joint disorder	☐ Heart Disease	☐ Liver Disease
☐ Asthma	☐ Hyperlipidemia	☐ Stroke
☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ COPD	☐ Other: _____	

Surgeries / Hospitalizations: Have you had any of the following surgeries? *(Please select all that apply and indicate the month and year, MM/YY)*

☐ Appendectomy, Date: _____	☐ C-Section, Date: _____	☐ Small Intestine Surgery, Date: _____
☐ Brain Surgery, Date: _____	☐ Eye Surgery, Date: _____	☐ Spine Surgery, Date: _____
☐ Breast Surgery, Date: _____	☐ Fracture Surgery, Date: _____	☐ Tonsillectomy, Date: _____
☐ CABG, Date: _____	☐ Hernia Repair, Date: _____	☐ Tubal Ligation, Full, Date: _____
☐ Cholecystectomy, Date: _____	☐ Hysterectomy, Full, Date: _____	☐ Valve Replacement, Date: _____
☐ Colon Surgery, Date: _____	☐ Joint Replacement, Date: _____	☐ Vasectomy, Date: _____
☐ Cosmetic Surgery, Date: _____	☐ Prostate Surgery, Date: _____	☐ Other: _____, Date: _____

Date Completed: _____

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Do you have any implants, artificial joints or discs, metal or anything that could impact therapy or imaging? ☐ Yes ☐ No

If YES, please describe: _____

Family History: Do you have a family history of any of the following? *(Please "X" the boxes that apply to you)*

	Alcohol/ Drug Addiction	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Stroke	Vision Problems	Gastrointestinal	Other
Mom															
Dad															
Sister															
Brother															
Mom's Mom															
Mom's Dad															
Dad's Mom															
Dad's Dad															
Mom's Sister															
Mom's Brother															
Dad's Sister															
Dad's Brother															

Immunization History: Have you had any of the following vaccines and/or illnesses? *(Please select all that apply)*

☐ Chicken Pox, Date: _____
☐ Rotavirus, Date: _____
☐ Hib, Date: _____
☐ Meningococcal, Date: _____
☐ Other: _____, Date: _____
☐ Measles, Date: _____
☐ Polio, Date: _____
☐ Pneumococcal, Date: _____
☐ Diphtheria, Tetanus, Pertussis (DTaP/Tdap), Date: _____
☐ Mumps, Date: _____
☐ Hepatitis B, Date: _____
☐ Flu (Influenza), Date: _____
☐ Rubella Date: _____
☐ Hepatitis A, Full, Date: _____
☐ HPV, Date: _____

Social History: Do you use any of the following tobacco products? *(Please select all that apply)*

Do you use tobacco products? ☐ Yes ☐ No

Smoking History:

☐ Current Every Day Smoker ☐ Current Smoker, Some Days ☐ Former Smoker ☐ Heavy Tobacco Smoker
☐ Light Tobacco Smoker ☐ Never Smoker ☐ Passive Smoke Exposure – Never Smoker
☐ Other: _____

nunm HEALTH CENTERS

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Date Completed: _____

MRN: _____

DOB: _____

Social History (Continued:

Type of Tobacco Used:

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew ☐ Other: _____

Start Date: _____ Quit Date: _____

Packs per day: ___ Years of smoking: ___Are you interested in learning about options to quit smoking?: ☐ Yes ☐ No

Alcohol Use: *(Please select all that apply)*

Do you drink alcohol? ☐ Yes ☐ No

If "YES", how many of the following per week?: _____ glasses of wine _____ cans of beer _____ shots of liquor

Do you currently use any of the following recreational or street drugs? *(Please select all that apply)*

☐ IV	☐ Cocaine	☐ Crack	☐ Ecstasy	☐ Heroin
☐ LSD	☐ Marijuana	☐ Meth	☐ Amphetamines	☐ Barbiturates
☐ Benzodiazepines	☐ Hashish	☐ Ketamine	☐ Mescaline	☐ Prescription Stimulants
☐ Nitrous Oxide	☐ Opioids	☐ PCP	☐ Psilocybin	☐ Inhalants
☐ E-cigs	☐ Nicotine Vaping	☐ Other: _____		

Sexual Orientation and Gender Identity: *(Please select all that apply)*

Do you think of yourself as: ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual
☐ Something else:_____ ☐ Don't know ☐ Choose not to disclose

What is your gender identity? *(Please select all that apply)*

☐ Female
☐ Male
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Female-to-Male (FTM)/Transgender Male Trans Man
☐ Additional Gender Category/(or Other)
☐ Choose not to disclose

What sex were you assigned at birth? *(Please select all that apply)*

☐ Female
☐ Male
☐ Unknown
☐ Not recorded on birth certificate
☐ Choose not to disclose
☐ Uncertain

Are you sexually active? ☐ Yes ☐ No ☐ Not Currently

Partners? ☐ Female ☐ Male ☐ Other: _____

What is your current birth control method? *(Please check all that apply)*

☐ Condom	☐ Pill	☐ Diaphragm	☐ IUD
☐ Surgical	☐ Spermicide	☐ Implant	☐ Rhythm
☐ Injection	☐ Sponge	☐ Inserts	☐ Abstinence
☐ Cervical Cap	☐ Hormone Patch	☐ IUS	☐ Vaginal Ring
☐ Withdrawal	☐ None	☐ Vasectomy	☐ Menopause

Have there been any major changes in the family lately: *(Please check all that apply)*

☐ None ☐ Move ☐ Job Change ☐ Separation ☐ Divorce ☐ Death in Family
☐ Other: _____

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Date Completed: _____

MRN: _____

DOB: _____

PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems?		
1. Little interest or pleasure in doing things	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all
2. Feeling down, depressed, or hopeless	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all

Food Security: *Please answer the following questions regarding your social history:*		
In the past year, we worried whether our food would run out before we could get more	☐ often true ☐ sometimes true	☐ never ☐ don't know /refused
In the past year, the food we bought just didn't last and we didn't have money to get more	☐ often true ☐ sometimes true	☐ never ☐ don't know /refused

Review of Systems: Please mark 'C' for any <u>current symptoms</u> *<u>(in the past 2 weeks)</u>*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

<u>Constitution</u>

Fever	☐ C	☐ P	Chills	☐ C	☐ P	Weight Loss	☐ C	☐ P
Fatigue	☐ C	☐ P	Sweating	☐ C	☐ P	Weakness	☐ C	☐ P

<u>Skin</u>

Rash	☐ C	☐ P	Itching	☐ C	☐ P	Other	☐ C	☐ P

<u>Head, Ears, Nose, Throat</u>

Hearing Loss	☐ C	☐ P	Ringing in Ears	☐ C	☐ P	Ear Pain	☐ C	☐ P
Ear Discharge	☐ C	☐ P	Nosebleeds	☐ C	☐ P	Congestion	☐ C	☐ P
Sinus Pain	☐ C	☐ P	Noisy Breathing/Stridor	☐ C	☐ P	Sore Throat	☐ C	☐ P

<u>Eyes</u>

Blurred Vision	☐ C	☐ P	Double Vision	☐ C	☐ P	Light Sensitivity	☐ C	☐ P
Eye Pain	☐ C	☐ P	Eye Discharge	☐ C	☐ P	Eye Redness	☐ C	☐ P

<u>Cardiovascular</u>

Chest Pain	☐ C	☐ P	Palpitations	☐ C	☐ P	Shortness of breath lying down	☐ C	☐ P
Leg Cramping/ Claudication	☐ C	☐ P	Leg Swelling	☐ C	☐ P	PND	☐ C	☐ P

<u>Respiratory</u>

Cough	☐ C	☐ P	Coughing up Blood	☐ C	☐ P	Sputum	☐ C	☐ P
Shortness of Breath	☐ C	☐ P	Wheezing	☐ C	☐ P			

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Review of Systems *(Continued):* Please mark 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Gastrointestinal

Heartburn	☐ C	☐ P	Nausea	☐ C	☐ P	Vomiting	☐ C	☐ P
Abdominal Pain	☐ C	☐ P	Diarrhea	☐ C	☐ P	Constipation	☐ C	☐ P
Blood in Stool	☐ C	☐ P	Black/Tarry Stools	☐ C	☐ P			

Genitourinary

Painful Urination	☐ C	☐ P	Urgency	☐ C	☐ P	Frequency	☐ C	☐ P
Blood in Urine	☐ C	☐ P	Flank/side Pain	☐ C	☐ P			

Male Sexed

Hernias	☐ C	☐ P	Testicular Masses	☐ C	☐ P

Female Sexed

Age of first menses	_____	Age of last menses	_____	Duration of menses	_____
Date of last annual exam	_____	Number of pregnancies	_____	Number of live births	_____
Number of miscarriages	_____	Number of abortions	_____		

Musculoskeletal

Muscle Pain	☐ C	☐ P	Neck Pain	☐ C	☐ P	Back Pain	☐ C	☐ P
Joint Pain	☐ C	☐ P	Falls	☐ C	☐ P			

Endocrine/ Heme/ Allergies

Easy Bruising/ Bleeding	☐ C	☐ P	Env. Allergies	☐ C	☐ P	Excessive Thirst	☐ C	☐ P

Neurological

Dizziness	☐ C	☐ P	Headaches	☐ C	☐ P	Tingling	☐ C	☐ P
Tremor	☐ C	☐ P	Sensory Change	☐ C	☐ P	Speech Change	☐ C	☐ P
Focal Weakness	☐ C	☐ P	Seizures	☐ C	☐ P	Fainting	☐ C	☐ P

Psychiatric

Depression	☐ C	☐ P	Suicidal Ideas	☐ C	☐ P	Substance Abuse	☐ C	☐ P
Hallucinations	☐ C	☐ P	Nervous/ Anxious	☐ C	☐ P	Insomnia	☐ C	☐ P
Memory Loss	☐ C	☐ P	Other	☐ C	☐ P			