

Legal Name * Last	First	Middle Initial	Suffix	Name used/Nickname:
Sex at Birth (please check one)* <input type="checkbox"/> Female <input type="checkbox"/> Male <small>*While CHP recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.</small>				Preferred Pronoun: (he, she, they, etc.)
Date of Birth	Month / Day / Year	Social Security #	Previous Name (First/Last) / Maiden Name	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone () Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone () Ok to leave voicemail/text? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work/Day Phone () Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred number to call: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work/Day
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Mailing/Billing Address	City	State	ZIP
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Home Address	City	State	ZIP
<input type="checkbox"/> CHECK BOX IF SAME AS MAILING ADDRESS			

Email Address:

Pharmacy Name	Pharmacy Street/Town	Pharmacy Phone Number
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If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.

Parent/Guardian Full Name	Parent/Guardian DOB	Phone Number	Relationship
	/ /		

CHP will send certain notification, such as bills, to your mailing address. How would you prefer to receive other types of notifications? (please check all that apply) Portal Communications Phone Text Letter Other: _____

This patient information is for demographic purposes only.

1) Racial Group(s) (Please check all that apply) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native American/Alaskan Native/Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: _____	2) Ethnicity (Please select one) <input type="checkbox"/> Hispanic/Latino Latin <input type="checkbox"/> Not Hispanic/Latino Latin 3) Agricultural Worker <input type="checkbox"/> No <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant	4) Preferred Language (Please select one) <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Français <input type="checkbox"/> Português <input type="checkbox"/> Русский <input type="checkbox"/> Other: _____ 5) US Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran <input type="checkbox"/> N/A	6) Employment Status <input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Retired <input type="checkbox"/> Not employed <input type="checkbox"/> Other: _____ 7) Student Status <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time
8) Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other: _____ 9) Homeless Status <input type="checkbox"/> Not homeless <input type="checkbox"/> Doubling up <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Street <input type="checkbox"/> Other: _____	10) What is your sexual orientation? <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't Know/Decline	11) What is your current gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or not exclusively male or female 12) What is your gender identity? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female-to-Male/Transgender Male <input type="checkbox"/> Male-to-Female/Transgender Female <input type="checkbox"/> Genderqueer or not exclusively male or female	

13) Referral Source (Please check all that apply) Self Friend/Family Health Provider Emergency Room
 Ad/Internet/Media/Outreach/Work/School Other: _____



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INSURANCE INFORMATION

Please give the front desk your insurance card so that we may have a copy on file. Please complete the insurance information below to ensure billing accuracy. If you have more than 2 insurances please notify the front desk.

Primary Policy Holder Last Name	First name	Middle Initial	Suffix	Date of Birth
Primary Policy Holder Social Security Number	Phone ()	Email Address		
Primary Policy Holder Mailing Address	City	State	Zip Code	

Secondary Policy Holder Last Name	First name	Middle Initial	Suffix	Date of Birth
Secondary Policy Holder Social Security Number	Phone ()	Email Address		
Secondary Policy Holder Mailing Address	City	State	Zip Code	

Medical/Dental Insurance #1		Medical/Dental Insurance #2	
Insurance Name	Insurance Plan Type <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Insurance Name	Insurance Plan Type <input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Member ID Number	Plan/Group Number	Member ID Number	Plan/Group Number
Effective Date		Effective Date	

GUARANTOR INFORMATION

Please fill out the information regarding the person responsible for paying bills not covered by the patient’s insurance. This may or may not be the policy holder of the insurance.

Please check this box if guarantor is the patient and sign below as guarantor.

Guarantor Last Name	First name	Middle Initial	Suffix	Date of Birth
Guarantor Social Security Number	Phone ()	Email Address		
Guarantor Mailing Address	City	State	Zip Code	

Guarantor Signature: _____ Date: _____

Based upon your earnings, you may be eligible for assistance/services that you are not aware of. This information allows CHP to receive valued grant funding which enables us to provide the wide variety of services our patients require.

\$10 MINIMAL FEE

2020 FEDERAL HHS POVERTY GUIDELINES * (Gross Annual Income) *****

ANNUAL INCOME: FAMILY SIZE	100% & BELOW	101% - 150%	151% - 200%	OVER 200%
1	\$ 12,760.00	\$ 19,140.00	\$ 25,520.00	\$ 31,900.00
2	\$ 17,240.00	\$ 25,860.00	\$ 34,480.00	\$ 43,100.00
3	\$ 21,720.00	\$ 32,580.00	\$ 43,440.00	\$ 54,300.00
4	\$ 26,200.00	\$ 39,300.00	\$ 52,400.00	\$ 65,500.00
5	\$ 30,680.00	\$ 46,020.00	\$ 61,360.00	\$ 76,700.00
6	\$ 35,160.00	\$ 52,740.00	\$ 70,320.00	\$ 87,900.00
7	\$ 39,640.00	\$ 59,460.00	\$ 79,280.00	\$ 99,100.00
8	\$ 44,120.00	\$ 66,180.00	\$ 88,240.00	\$ 110,300.00
For Each Additional Person Add:	\$ 4,480.00			

1) What is your family’s gross income? _____

Yearly Monthly
 Every 2 Weeks Weekly

Family size: _____

2) Please enter head of household:

Self Other _____

Patient Declined



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INVOLVEMENT IN CARE

I hereby request the following individual(s) be allowed to participate in my care or payment decision process. I understand that this individual(s) may be given health or payment information about me if I am unavailable or unable to communicate. CHP will act on this information until I revoke or amend this authorization in writing. In the event the person listed below is involved in healthcare decisions for me, a health care proxy must be completed.

Full Name	Relationship	Phone ()	Information To Be Released <input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Billing <input type="checkbox"/> Appointment Scheduled <input type="checkbox"/> Other _____
Full Name	Relationship	Phone ()	Information To Be Released <input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Billing <input type="checkbox"/> Appointment Scheduled <input type="checkbox"/> Other _____
Full Name	Relationship	Phone ()	Information To Be Released <input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Billing <input type="checkbox"/> Appointment Scheduled <input type="checkbox"/> Other _____

Do not disclose any information to any person.

Patient Signature: _____ Date: _____

CONTACT INFORMATION

Please fill out all pertinent contact information below.

Guardian Last Name	First Name	Middle Initial	Suffix
Guardian Primary Phone	Cell Phone ()	Work Phone ()	

Primary Emergency Contact Last Name	First Name	Relationship
Emergency Contact Primary Phone ()	Cell Phone ()	Work Phone ()

Secondary Emergency Contact Last Name	First Name	Relationship
Emergency Contact Primary Phone ()	Cell Phone ()	Work Phone ()

Patient's Employer Name	Employer Full Address	
Employer's Phone ()	Patient Occupation	Are you covered under your employer's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

Patient's School Full Name	School Full Address	
School Phone ()	Are you covered under your school's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Consent for Treatment

Patient Name: _____

Date: _____

I hereby give my consent and authorize Community Health Programs (CHP) to treat any medical, dental, or behavioral health condition providing that the provider has explained the condition to me, the treatment procedures and alternative methods of treating my condition. The provider will/has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which is not known previously.

I understand that CHP integrates medical, dental, nutrition, physical therapy, obstetrics/gynecology, behavioral health, and family services. As a result these additional professionals may be part of my treatment team and experience, which may result in my being seen by these providers and may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient insurance coverage, I will be held responsible for the remaining balance.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all associated CHP visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify for CHP's Sliding Fee Scale via the Sliding Fee Application process administered by CHP's patient assistance enrollment specialist.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that CHP may use data developed for and/or provided by patients to determine general characteristics of the communities it serves; that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have been notified of CHP's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature: _____

Date: _____

Guardian/Legal Signature: _____

Date: _____

General Information: Informed consent will be obtained from all patients accessing CHP services. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education. Signature will stay valid unless otherwise revoked by patient in writing.

The patient and/or family, as appropriate, is given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The provider primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.



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HEALTH HISTORY

Welcome to our practice. Please fill out the information below to the best of your ability.

Patient Last Name	First Name	Patient DOB: / /	Patient #:	Today's Date: / /
Chief Complaint:				

Past Medical History

Have you ever had the following: (Please check the "No" or "Yes" box where appropriate, leave blank if uncertain.)

Measles <input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes	Back Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes	
Mumps <input type="checkbox"/> No <input type="checkbox"/> Yes	Bladder Infections <input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes
Chickenpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Low Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy <input type="checkbox"/> No <input type="checkbox"/> Yes
Whooping Cough <input type="checkbox"/> No <input type="checkbox"/> Yes	Migraine Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids <input type="checkbox"/> No <input type="checkbox"/> Yes
Scarlet Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes	Diphtheria <input type="checkbox"/> No <input type="checkbox"/> Yes
Bleeding Tendency <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Pneumonia <input type="checkbox"/> No <input type="checkbox"/> Yes	Smallpox <input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	Hives or Eczema <input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Polio <input type="checkbox"/> No <input type="checkbox"/> Yes
AIDS or HIV <input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma <input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia <input type="checkbox"/> No <input type="checkbox"/> Yes
Infectious Mono <input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral Valve Prolapse <input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis <input type="checkbox"/> No <input type="checkbox"/> Yes
Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes	Sexually Transmitted Infection(s) <input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Date of Last X-Ray _____	Blood/Plasma Transfusions <input type="checkbox"/> No <input type="checkbox"/> Yes

Please list any other disease(s):

Please list any previous Hospitalizations/Surgeries/Illnesses/Dental Procedures below:

Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State
Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State
Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State

Please list any current medications (including non-prescription) below:

Name and Dosage	Name and Dosage	Name and Dosage	Name and Dosage
Name and Dosage	Name and Dosage	Name and Dosage	Name and Dosage

Patient Social History: Please check the appropriate box next to each topic below:

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Use of Alcohol: <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Use of Tobacco: <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never Previously, but quit: _____ Current packs per day: _____
Use of Vaping: <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never Previously, but quit: _____ Current pods/cartridges per day: _____
Use of Drugs(including marijuana): <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Never Previously, but quit: _____
Excessive exposure at home or work to: <input type="checkbox"/> Fumes <input type="checkbox"/> Dust <input type="checkbox"/> Solvents <input type="checkbox"/> Air-borne Particles <input type="checkbox"/> Noise

Family Medical History – Please fill out all applicable information below:

Father	Age	Diseases	If Deceased, Cause of Death
Mother	Age	Diseases	If Deceased, Cause of Death
Sibling	Age	Diseases	If Deceased, Cause of Death
Spouse	Age	Diseases	If Deceased, Cause of Death
Children	Age	Diseases	If Deceased, Cause of Death



Review of Systems – Pediatric (Male)

Patient Name	Date of Birth / /	Today's Date / /
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In the past month have you had or do you currently have:

<p>Constitutional <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> chills <input type="checkbox"/> <input type="checkbox"/> decreased activity <input type="checkbox"/> <input type="checkbox"/> decreased appetite <input type="checkbox"/> <input type="checkbox"/> fever Duration: _____ Tmax: _____ <input type="checkbox"/> <input type="checkbox"/> fussiness <input type="checkbox"/> <input type="checkbox"/> irritability <input type="checkbox"/> <input type="checkbox"/> lethargy (lack of energy/enthusiasm) <input type="checkbox"/> <input type="checkbox"/> weight gain <input type="checkbox"/> <input type="checkbox"/> weight loss Other: _____</p>	<p>Respiratory <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> difficulty breathing (dyspnea) <input type="checkbox"/> <input type="checkbox"/> stridor (wheezing) <input type="checkbox"/> <input type="checkbox"/> use of accessory muscles <input type="checkbox"/> <input type="checkbox"/> cough Quality: _____ Frequency: _____ <input type="checkbox"/> <input type="checkbox"/> known TB exposure <input type="checkbox"/> <input type="checkbox"/> sputum <input type="checkbox"/> <input type="checkbox"/> wheezing (TB risk factor) Other: _____</p>	<p>Gastrointestinal (Abdomen) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> abdominal pain <input type="checkbox"/> <input type="checkbox"/> constipation <input type="checkbox"/> <input type="checkbox"/> diarrhea <input type="checkbox"/> <input type="checkbox"/> nausea <input type="checkbox"/> <input type="checkbox"/> reflux <input type="checkbox"/> <input type="checkbox"/> vomiting Other: _____</p>
<p>HEENT <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> difficulty swallowing (dysphagia) <input type="checkbox"/> <input type="checkbox"/> ear discharge <input type="checkbox"/> <input type="checkbox"/> cross-eyed appearance (esotropia) <input type="checkbox"/> <input type="checkbox"/> eye discharge <input type="checkbox"/> <input type="checkbox"/> eye redness <input type="checkbox"/> <input type="checkbox"/> headaches <input type="checkbox"/> <input type="checkbox"/> hearing loss <input type="checkbox"/> <input type="checkbox"/> nasal congestion <input type="checkbox"/> <input type="checkbox"/> ear pain (otalgia) <input type="checkbox"/> <input type="checkbox"/> sore throat (pharyngitis) <input type="checkbox"/> <input type="checkbox"/> runny nose (rhinorrhea) <input type="checkbox"/> <input type="checkbox"/> sneezing <input type="checkbox"/> <input type="checkbox"/> tearing <input type="checkbox"/> <input type="checkbox"/> vision loss Other: _____</p>	<p>Cardiovascular (Heart/Circulation) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> chest pain <input type="checkbox"/> <input type="checkbox"/> irregular heartbeat/palpitations <input type="checkbox"/> <input type="checkbox"/> temporary loss of consciousness (syncope) Other: _____</p>	<p>Genitourinary (Kidneys & Bladder) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> decreased urine output <input type="checkbox"/> <input type="checkbox"/> painful urination (dysuria) <input type="checkbox"/> <input type="checkbox"/> uncontrolled urination (enuresis) <input type="checkbox"/> <input type="checkbox"/> flank pain <input type="checkbox"/> <input type="checkbox"/> foul urine odor <input type="checkbox"/> <input type="checkbox"/> blood in urine (hematuria) <input type="checkbox"/> <input type="checkbox"/> excessive urination (polyuria) Other: _____</p>
<p>Metabolic/Endocrine <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> excessive thirst (polydipsia) <input type="checkbox"/> <input type="checkbox"/> excessive urination (polyuria) <input type="checkbox"/> <input type="checkbox"/> abnormal sleep pattern Other: _____</p>	<p>Vascular <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> cool extremity <input type="checkbox"/> <input type="checkbox"/> bluish cast to the skin (cyanosis) Other: _____</p>	<p>Reproductive (Male) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> circumcised <input type="checkbox"/> <input type="checkbox"/> penile discharge <input type="checkbox"/> <input type="checkbox"/> scrotum testicular mass <input type="checkbox"/> <input type="checkbox"/> scrotum testicular pain Other: _____</p>
<p>Integumentary (Skin) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> acne <input type="checkbox"/> <input type="checkbox"/> itchy skin (pruritus) <input type="checkbox"/> <input type="checkbox"/> rash Other: _____</p>	<p>Hematologic <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> easy bleeding <input type="checkbox"/> <input type="checkbox"/> easy bruising <input type="checkbox"/> <input type="checkbox"/> enlarged lymph nodes (lymphadenopathy) <input type="checkbox"/> <input type="checkbox"/> bleeding under the skin (petechiae) Other: _____</p>	<p>Neuro/Psychiatric <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> inappropriate interaction <input type="checkbox"/> <input type="checkbox"/> behavioral changes <input type="checkbox"/> <input type="checkbox"/> inconsolable <input type="checkbox"/> <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> <input type="checkbox"/> distorted body image <input type="checkbox"/> <input type="checkbox"/> self conscious <input type="checkbox"/> <input type="checkbox"/> abnormal sleep pattern Other: _____</p>
<p>Musculoskeletal <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> bone pain <input type="checkbox"/> <input type="checkbox"/> joint pain <input type="checkbox"/> <input type="checkbox"/> joint swelling <input type="checkbox"/> <input type="checkbox"/> muscle weakness <input type="checkbox"/> <input type="checkbox"/> myalgia Other: _____</p>	<p>Immunological (Immune System) <input type="checkbox"/> All Not Applicable YES NO <input type="checkbox"/> <input type="checkbox"/> allergic rhinitis (seasonal allergies) <input type="checkbox"/> <input type="checkbox"/> environmental allergies <input type="checkbox"/> <input type="checkbox"/> food allergies <input type="checkbox"/> <input type="checkbox"/> urticaria Other: _____</p>	<p>Other: _____</p>



PLEASE FILL OUT THE SOCIAL NEEDS SCREENING THAT APPLIES TO THE PATIENT

Pediatric Social Needs Screening (0 – 17 years of age)

Because we care, this questionnaire is used to help understand your needs.

Based on the answers, we may be able to provide information on resources available to you.

Patient Full Name	Patient Date of Birth / /	Date of Questionnaire / /
<p>1. In the past year, has your child been unable to get any of the following when it was really needed? (Please select one answer to <u>each</u> question).</p> <p>Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p> <p>Clothing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p> <p>Utilities (heat, electricity, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p> <p>Medicine or any health care need (medical, dental, mental health or vision) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p> <p>Other (please specify): _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>		
<p>2. Are you worried about losing current housing for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>	<p>3. Has lack of transportation kept you from getting your child to medical appointments, school or from getting things needed for daily living? <input type="checkbox"/> Yes, it has kept my child from medical appointments or from getting their medications. <input type="checkbox"/> Yes, it has kept my child from non-medical meetings, school or getting things needed for daily living. <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>	
<p>4. Do you believe that your child feels emotionally and physically safe at home, school, and in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>	<p>5. Does your child attend school regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>	
<p>6. Does your child ever feel alone or isolated from friends, family or anyone else in their life? <input type="checkbox"/> Yes, my child does feel alone or isolated. <ul style="list-style-type: none"> • How often? (please check one selection below) <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/> No, my child does not feel alone or isolated. <input type="checkbox"/> Unclear <input type="checkbox"/> I choose not to answer this question.</p>		



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PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have the right to:

- Take part in your health care and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment, including options for your care
- Change medical providers at Community Health Programs (CHP)
- Obtain another opinion about your illness or treatment
- Privacy of your health records
- Talk with the clinical manager about any questions or problems with your care
- Know about services available through Community Health Programs (CHP)
- Respect of your cultural, social, spiritual, and personal values and beliefs
- Know about legal reporting requirements
- Request special accommodations if you have a disability
- Request assistance with a living will or durable power of attorney for health care
- Refuse treatment, care, and services as allowed by law
- Be aware of the cost of your care and ways you may pay for your care
- Refuse to be included in any research program without limiting medical care or treatment

As a patient, you have the responsibility to:

- Inform your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both care givers and other patients
- Cancel or reschedule appointments a minimum of 24 hours prior so that another person may receive care in that time slot
- Pay your copayment and bills on time
- Use medications or medical devices for personal use only
- Inform the medical provider if you become worse or have an unexpected reaction to a medication
- Provide at least 48 hours' notice for prescription refills which may take longer for certain medications. **Note:** Prescriptions are NOT refilled after hours, on weekends, or holidays.
NARCOTICS ARE NOT PRESCRIBED WITHOUT AN APPOINTMENT
- Provide written permission to release your other health records to Community Health Programs, Inc. (CHP) when necessary
- Provide Community Health Programs (CHP) a copy of your living will or durable power of attorney for health care matters

Additional Information:

- **After Hours Care:** We have 24-hour on-call coverage through an answering service. If your call is regarding an appointment, referral, billing or prescription refill, we ask that you call during normal operating hours.
- **Forms:** We are happy to fill out physical forms, camp forms, college forms if you have had your yearly physical. Please give the office at least one week to complete and return the forms to you. Otherwise, you may bring them with you at your physical appointment.

**If you have any questions, please tell your medical provider or the clinical manager.
(For patient awareness, please take this page home with you)**