

PATIENT INFORMATION SHEET

1. Patient Information

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

SEX: **(Please circle)** Male Female AGE: _____

NATIONALITY **(Please circle)** Caucasian Black Indian Asian Hispanic
Other: _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

CELLPHONE: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ SOCIAL SECURITY No: _____

LANGUAGE: _____

EMERGENCY CONTACT NAME /NUMBER: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ BUS PHONE: _____

2. Medical Insurance Information (optional)

MEDICAL INSURANCE: (PRIMARY): _____ POLICY NO: _____

ADDRESS OF INSURANCE CO: _____ PHONE: _____

3. Authorization Agreement

The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for service when rendered, unless arrangements are made in advance.

I hereby request and consent to diagnostic procedures, including CHDP examinations, XRAYs, blood tests, medical treatments, including immunizations.

I (self or parent/legal guardian) hereby authorize Allied Health Solutions to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered. I agree to settle all claims by arbitration.

Name: _____ Date: _____

Allied Health Solutions Medical Group

[illegible]

Name: _____ Date: _____

Medical History

1. Name: _____ Age: _____
2. Marital Status: _____
3. Number of Children: _____
4. Hospitalizations: _____
5. Surgeries: _____
6. What kind of surgeries? _____
7. Allergies: _____
8. Are you currently taking any medications: _____
9. Do you drink alcohol? _____ Do you smoke _____
10. When was your last TB shot? _____
11. When was your last tetanus shot? _____
12. Have you had any of the problems below?

Chicken Pox _____	Underweight _____
Ear infection _____	Epilepsy _____
Sinus problems _____	Seizure Disorders _____
Hay fever _____	Mumps _____
Pneumonia _____	Bladder Infections _____
Sickle Cell _____	Eczema _____
Frequent headaches _____	Heart Murmur _____
Anemia _____	Vision Problem _____
Over weight _____	Wandering Eye _____

Name: _____ Date: _____

ALLIED HEALTH SOLUTIONS MEDICAL GROUP

301 N Prairie Avenue, Suite 230, Inglewood, CA 90301

Tel: 323 944 0949, Fax: 323 782 0388

DISABILITY EVALUATION QUESTIONNAIRE

DATE DISABILITY BEGAN: _____

LAST DATE WORKED: _____

- 1. WHAT ARE YOUR SPECIFIC SYMPTOMS? (DO NOT USE ANXIETY OR DEPRESSION AS THEY ARE DIAGNOSIS AND NOT SYMPTOMS):**
- 2. WHAT ARE YOUR TASKS, DUTIES AND RESPONSIBILITIES AT WORK?**
- 3. EXPLAIN WHY YOU ARE UNABLE TO PERFORM THE DUTIES THAT YOU LISTED ABOVE (DO NOT USE ANXIETY OR DEPRESSION AS A REASON FOR YOU NOT BEING ABLE TO PERFORM YOUR JOB FUNCTIONS):**

Name: _____

Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over 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's 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

ALLIED HEALTH SOLUTIONS MEDICAL GROUP

301 N Prairie Avenue, Suite 230, Inglewood, CA 90301

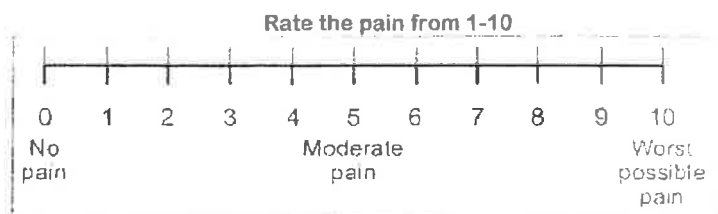
Tel: 323 944 0949, Fax: 323 782 0388

Pain Assessment

Mark an (X) to description of pain

Location: _____

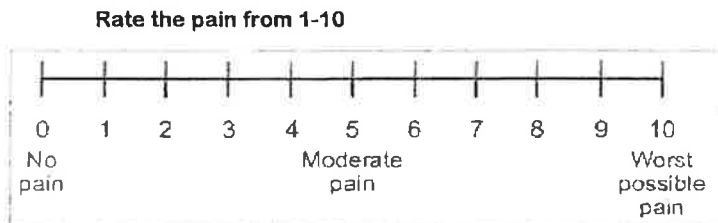
- ☐ Sharp
- ☐ Dull
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Burning
- ☐ Other: _____



Mark an (X) to description of pain

Location: _____

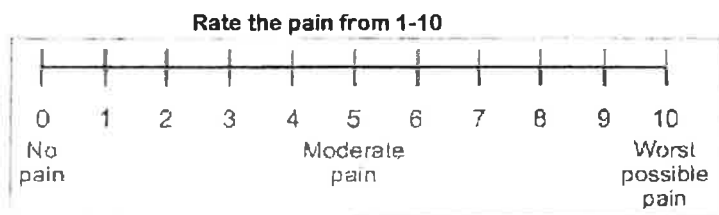
- ☐ Sharp
- ☐ Dull
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Burning
- ☐ Other: _____



Mark an (X) to description of pain

Location: _____

- ☐ Sharp
- ☐ Dull
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Burning
- ☐ Other: _____



Patient's signature: _____ Date: _____

Allied Health Solutions Medical Group

301 N Prairie Avenue, Suite 230, Inglewood, CA 90301

Tel: 323-944-0949, Fax: 323-782-0388

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization allows the healthcare provider (s) named below to release confidential information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize:

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: ALLIED HEALTH SOLUTIONS MEDICAL GROUP

Address: 301 N Prairie Ave, Unit 230

City: Inglewood State: California Zip Code: 90301

The medical information will be used for the following purpose: _____

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (Initial)

Tests for Antibodies to HIV _____ (Initial)

Psychiatric/Mental Health _____ (Initial)

HIV Diagnosis/Treatment _____ (Initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient or legal/personal representative

Relationship if other than patient

Patient's Full Name

Date

Patient's Social Security Number

Patient's Date of Birth

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2) which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.