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

Name_____

Date: _____

Date of Birth: _____

MEDICATIONS	DATE BEGAN	DIRECTIONS

Medical History

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

Chicken Pox_____
Ear infection_____
Sinus problems_____
Hay fever_____
Pneumonia_____
Sickle Cell_____
Frequent headaches_____
Anemia_____
Overweight_____

Underweight_____
Epilepsy_____
Seizure Disorders_____
Mumps_____
Bladder Infections_____
Eczema_____
Heart Murmur_____
Vision Problem_____
Wandering Eye_____

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**

Pain Assessment

Name:_____
Date:_____
Date of Birth:_____

Location of pain: #1_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|
Location of pain: #2_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|
Location of pain: #3_____	Rate Pain 0 (no Pain) to 10 (Worst Possible Pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Type of Pain	☐ ☐ Sharp | ☐ Dull| ☐ Stabbing| ☐ Throbbing| ☐ Aching| ☐ Burning| ☐ Numb|

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.