

Primary Care Provider (PCP)		Date (MM/DD/YYYY) *
Last Name *	First Name *	Middle
Former Name		Date of Birth (MM/DD/YYYY) *

Marital Status (select one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Is this your legal name? ☐ Yes ☐ No If not, legal name:

GENDER IDENTITY (SELECT ALL THAT APPLY)

- ☐ Male ☐ Female ☐ Transgender Male / Trans Man ☐ Transgender Female / Trans Woman ☐ Non-binary
☐ Genderqueer / Gender non-conforming ☐ Prefer not to answer
☐ Prefer to self-describe:

My pronouns are: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:

ADDRESS AND CONTACT

Street Address *		Phone *	
P.O. Box	City *	State *	ZIP Code *
Email Address			

WORK

Occupation	Employer	Employer Phone
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How did you choose our clinic? (select one)

- ☐ Doctor referral ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home / work ☐ Yellow Pages
☐ Other:

PHARMACY

Pharmacy Name	Pharmacy Phone
Pharmacy Address	

LOCAL FRIEND OR RELATIVE (NOT LIVING AT THE SAME ADDRESS)

Name	Relationship	Home Phone	Work Phone
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CONSENT AND ACKNOWLEDGMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cardin HealthCare, Inc. or my insurance company to release any information required to process my claims. By signing, I also agree to medical treatment.

☐ I have read and agree to the statement above.

Patient / Guardian Signature *	Date (MM/DD/YYYY) *
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☐ By checking this box and typing my first and last name above, I acknowledge that this will serve as my legal signature on this form.

Patient Name (first, last) *	Home Phone
Street Address	City / State / ZIP

ALTERNATE COMMUNICATION METHOD

Is it OK to contact you by email? ☐ Yes ☐ No Initials:

Is it OK for us to text you? ☐ Yes ☐ No Initials:

Email Address	Cell Phone for Texts
---------------	----------------------

This is how we will contact you if we need to talk with you about eligibility, appointments, authorizations, and/or results.

IF VOICEMAIL, AN ANSWERING MACHINE, OR SOMEONE OTHER THAN THE PATIENT ANSWERS THE PHONE (SELECT ONE)

- ☐ OK to leave the name of the office and the reason for the call. Initials:
- ☐ Leave the name of the office as the caller and ask that I call back. Initials:
- ☐ Leave the office number only and ask that I call back. Initials:
- ☐ Do not leave any messages. Initials:

RESTRICTED DISCLOSURES OF PATIENT INFORMATION

Information	Restriction

FAMILY MEMBERS / FRIENDS INVOLVED IN MY CARE

- ☐ OK to disclose information to any person who says they are a family member or friend listed below, only with my written consent. Initials:

OK to disclose information only to the following family members or friends (check all that apply):

- ☐ Spouse:
- ☐ Children:
- ☐ Parents:
- ☐ Siblings / Other (name):
- ☐ Do not disclose information to any person, regardless of relationship.
- ☐ I have received a copy of the Notice of Privacy Practices for Cardin HealthCare, Inc.

Patient / Guardian Signature *	Date (MM/DD/YYYY) *
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☐ By checking this box and typing my first and last name above, I acknowledge that this will serve as my legal signature on this form.

If signed by someone other than the patient: name and relationship

Name

Age

Date of Birth

Date

MALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

☐ Yes ☐ No Are you allergic to any medications? List here:

☐ Yes ☐ No Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here:

☐ Yes ☐ No Do you have a usual source of primary care? If yes, who?

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

- | | | |
|--|--|--|
| 1. ☐ Heart attack/disease | 5. ☐ High cholesterol | 9. ☐ Mental illness |
| 2. ☐ Stroke | 6. ☐ Diabetes | 10. ☐ Maternal DES exposure |
| 3. ☐ Blood clot in legs/lungs | 7. ☐ Alcohol or drug abuse | 11. ☐ Cancer |
| 4. ☐ High blood pressure | 8. ☐ Birth defects/genetic problems | 12. ☐ I do not know my family medical history |

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

- | | | |
|--|---|---|
| A. ☐ Heart disease | J. ☐ Anemia | R. ☐ Liver problems or hepatitis |
| B. ☐ High blood pressure | K. ☐ Sickle cell disease | S. ☐ Gall bladder disease |
| C. ☐ Stroke | L. ☐ Kidney/bladder problems | T. ☐ Eating disorder |
| D. ☐ Diabetes | M. ☐ Seizures or epilepsy | U. ☐ Cancer |
| E. ☐ High cholesterol | N. ☐ Depression | Type: <input type="text"/> |
| F. ☐ Tuberculosis (TB) | O. ☐ Suicidal thoughts | V. ☐ Thyroid disease |
| G. ☐ Asthma | P. ☐ Mental illness | W. ☐ Infertility |
| H. ☐ Blood clot in legs/lungs | Q. ☐ Severe headaches or migraines | |
| I. ☐ Bleed/bruise easily | | |

2. ☐ Yes ☐ No Have you ever been hospitalized or had any surgery?

If yes, when and why?

3. ☐ Yes ☐ No Have you ever had a transfusion or blood exposure?

4. ☐ Yes ☐ No Have you been immunized against rubella? ☐ I do not know

5. ☐ Yes ☐ No Have you been immunized against hepatitis B? ☐ I do not know

6. When was your last genital exam? ☐ I never had a genital exam

☐ Yes ☐ No Were you ever told there was any problem?

If yes, what?

7. ☐ Yes ☐ No Have you ever had an HIV test?

If yes, when was your last one?

Was it: ☐ Positive ☐ Negative?

C. Contraception History:

1. How old were you when you first had intercourse? years old ☐ I never had sex

2. How important is it for you to avoid pregnancy now? ☐ Very ☐ Somewhat ☐ Not at all

3. What birth control methods have you and your partner(s) used in the past? ☐ None

- | | | |
|---|---|--|
| A. ☐ Condoms/rubbers | F. ☐ IUD | J. ☐ Foam/film or jelly |
| B. ☐ Birth control pills | G. ☐ Implants under the skin | K. ☐ Withdrawal/pulling out |
| C. ☐ DepoProvera/shot | H. ☐ Diaphragm/cervical cap | L. ☐ Rhythm method |
| D. ☐ Patch | I. ☐ Tubal ligation/tubes tied | M. ☐ Vasectomy |
| E. ☐ NuvaRing (vaginal ring) | | |

4. What birth control are you and your partner(s) currently using? ☐ None

5. ☐ Yes ☐ No Are you happy with your method?

6. How often do you use condoms? ☐ Always ☐ Sometimes ☐ Never

7. ☐ Yes ☐ No Have you ever used emergency contraception (morning after pill/Plan B)?

8. ☐ Yes ☐ No Have you ever gotten anyone pregnant? ☐ Unsure

9. ☐ Yes ☐ No ☐ Maybe Are you and your partner planning to get pregnant in the next two years?

Provider notes:

D. Habit and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? ☐ None
2. ☐ Yes ☐ No Do you smoke cigarettes? If yes, how many cigarettes per day?
3. ☐ Yes ☐ No Do you use street drugs? If yes, please list:
4. ☐ Yes ☐ No Have you ever used injected drugs?
5. ☐ Yes ☐ No Have you ever shared needles?
6. ☐ Yes ☐ No Has anyone ever told you that you have a problem with drugs or alcohol?
7. ☐ Yes ☐ No Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
8. ☐ Yes ☐ No Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of: ☐ Injected drug use ☐ HIV

E. Sexual History:

In the last 12 months...

1. ☐ Yes ☐ No Have you been sexually active? If no, skip to #6.
If yes, how many sexual partners have you had?
2. Have you had sex with: ☐ Men ☐ Women ☐ Both?
3. Have you and/or your partner(s) had: ☐ Oral sex ☐ Anal sex ☐ Vaginal sex?
4. ☐ Yes ☐ No Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
☐ Yes, definitely ☐ Not sure, possibly ☐ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
A. ☐ Chlamydia D. ☐ Trichomoniasis (Trich) G. ☐ Syphilis
B. ☐ Gonorrhea E. ☐ Pelvic Inflammatory Disease H. ☐ Other:
C. ☐ Genital Herpes F. ☐ Genital warts
7. ☐ Yes ☐ No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

Patient Signature/Date

Clinician Signature/Date

☐ By checking this box and typing my first and last name above, I acknowledge that this will serve as my legal signature on this form.

Clinician Signature/Date Updated

Clinician Signature/Date Updated

2880 Atlantic Ave
Suite 110/210
Long Beach, CA, 90806
Tel: (562) 424-4404
Fax: (562) 424-4770
pcp@cardin-healthcare.com

Provider notes:

Staying Healthy Assessment

Adult

Patient's Name (first & last)		Date of Birth		☐ Female	Today's Date
				☐ Male	
Person Completing Form (if patient needs help)		☐ Family Member	☐ Friend	Need help with form?	
		☐ Other (Specify)		☐ Yes ☐ No	
Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.					Need Interpreter? ☐ Yes ☐ No
					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	☐ Yes	☐ No	☐ Skip	Nutrition
2	Do you eat fruits and vegetables every day?	☐ Yes	☐ No	☐ Skip	
3	Do you limit the amount of fried food or fast food that you eat?	☐ Yes	☐ No	☐ Skip	
4	Are you easily able to get enough healthy food?	☐ Yes	☐ No	☐ Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	☐ No	☐ Yes	☐ Skip	
6	Do you often eat too much or too little food?	☐ No	☐ Yes	☐ Skip	
7	Are you concerned about your weight?	☐ No	☐ Yes	☐ Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	☐ Yes	☐ No	☐ Skip	Physical Activity
9	Do you feel safe where you live?	☐ Yes	☐ No	☐ Skip	Safety
10	Have you had any car accidents lately?	☐ No	☐ Yes	☐ Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	☐ No	☐ Yes	☐ Skip	
12	Do you always wear a seat belt when driving or riding in a car?	☐ Yes	☐ No	☐ Skip	
13	Do you keep a gun in your house or place where you live?	☐ No	☐ Yes	☐ Skip	Dental Health
14	Do you brush and floss your teeth daily?	☐ Yes	☐ No	☐ Skip	
15	Do you often feel sad, hopeless, angry, or worried?	☐ No	☐ Yes	☐ Skip	
16	Do you often have trouble sleeping?	☐ No	☐ Yes	☐ Skip	Mental Health
17	Do you smoke or chew tobacco?	☐ No	☐ Yes	☐ Skip	
18	Do friends or family members smoke in your house or place where you live?	☐ No	☐ Yes	☐ Skip	
					Alcohol, Tobacco, Drug Use

19	In the past year, have you had: ☐ (men) 5 or more alcohol drinks in one day? ☐ (women) 4 or more alcohol drinks in one day?	☐ No	☐ Yes	☐ Skip	Sexual Issues
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	☐ No	☐ Yes	☐ Skip	
21	Do you think you or your partner could be pregnant?	☐ No	☐ Yes	☐ Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	☐ No	☐ Yes	☐ Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	☐ No	☐ Yes	☐ Skip	
24	Have you or your partner(s) had sex with other people in the past year?	☐ No	☐ Yes	☐ Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	☐ No	☐ Yes	☐ Skip	Other Questions
26	Have you ever been forced or pressured to have sex?	☐ No	☐ Yes	☐ Skip	
27	Do you have other questions or concerns about your health?	☐ No	☐ Yes	☐ Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	☐ Patient Declined the SHA
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	
PCP's Signature: _____	Print Name: _____	Date: _____			
SHA ANNUAL REVIEW					
PCP's Signature: _____	Print Name: _____	Date: _____			
PCP's Signature: _____	Print Name: _____	Date: _____			
PCP's Signature: _____	Print Name: _____	Date: _____			
PCP's Signature: _____	Print Name: _____	Date: _____			

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?¹
 - ☐ Yes
 - ☐ No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)²
 - ☐ Bug infestation
 - ☐ Mold
 - ☐ Lead paint or pipes
 - ☐ Inadequate heat
 - ☐ Oven or stove not working
 - ☐ No or not working smoke detectors
 - ☐ Water leaks
 - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.³
 - ☐ Often true
 - ☐ Sometimes true
 - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.³
 - ☐ Often true
 - ☐ Sometimes true
 - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?¹
 - ☐ Yes
 - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?⁴
 - ☐ Yes
 - ☐ No
 - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?⁵
 - ☐ Yes
 - ☐ No

EMPLOYMENT

8. Do you have a job?⁶
 - ☐ Yes
 - ☐ No

EDUCATION

9. Do you have a high school degree?⁶
 - ☐ Yes
 - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:⁷
 - ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?⁸
 - ☐ Never (1)
 - ☐ Rarely (2)
 - ☐ Sometimes (3)
 - ☐ Fairly often (4)
 - ☐ Frequently (5)
12. How often does anyone, including family, insult or talk down to you?⁸
 - ☐ Never (1)
 - ☐ Rarely (2)
 - ☐ Sometimes (3)
 - ☐ Fairly often (4)
 - ☐ Frequently (5)

13. How often does anyone, including family, threaten you with harm?⁸
- ☐ Never (1)
 - ☐ Rarely (2)
 - ☐ Sometimes (3)
 - ☐ Fairly often (4)
 - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?⁸
- ☐ Never (1)
 - ☐ Rarely (2)
 - ☐ Sometimes (3)
 - ☐ Fairly often (4)
 - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
- ☐ Yes
 - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14:

Greater than 10 equals positive screen for personal safety.

REFERENCES

1. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical care. *J Health Care Poor Underserved*. 2015;26(2):321-327.
3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*. 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics*. 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. <http://www.childrenshealthwatch.org/methods/our-survey/>. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics*. 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan*. 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med*. 1998;30(7):508-512.

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Patient Name (first, last) *	Date of Birth (MM/DD/YYYY)	Date

AUDIT-C: ALCOHOL USE

1. How often do you have a drink containing alcohol?

- ☐ Never
 ☐ Monthly or less
 ☐ 2 to 4 times a month
 ☐ 2 to 3 times a week
 ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ 1 or 2
 ☐ 3 or 4
 ☐ 5 or 6
 ☐ 7 to 9
 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ Never
 ☐ Less than monthly
 ☐ Monthly
 ☐ Weekly
 ☐ Daily or almost daily

DAST-10: DRUG USE QUESTIONS

These questions are about drug use in the past 12 months. Do not include alcohol or tobacco.

- | | |
|---|--|
| 1. Have you used drugs other than those required for medical reasons? | ☐ Yes ☐ No |
| 2. Do you abuse more than one drug at a time? | ☐ Yes ☐ No |
| 3. Are you unable to stop using drugs when you want to? | ☐ Yes ☐ No |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | ☐ Yes ☐ No |
| 5. Do you ever feel bad or guilty about your drug use? | ☐ Yes ☐ No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | ☐ Yes ☐ No |
| 7. Have you neglected your family because of your use of drugs? | ☐ Yes ☐ No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | ☐ Yes ☐ No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | ☐ Yes ☐ No |
| 10. Have you ever had medical problems as a result of your drug use (for example: memory loss, hepatitis, convulsions, bleeding)? | ☐ Yes ☐ No |

OFFICE USE ONLY

AUDIT-C Score (0 to 12)	DAST-10 Score (0 to 10)	Provider

DAST-10 Suggested Action:

- ☐ 0: No problems reported, none at this time
 ☐ 1 to 2: Low level, monitor and reassess in 1 year
☐ 3 to 5: Moderate level, further investigation
 ☐ 6 to 8: Substantial level, intensive assessment
☐ 9 to 10: Severe level, intensive assessment

Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool

Please read each of the following activities and place a check mark in the box that best indicates the frequency with which your partner acts in the way depicted.

Date:

Name:

Age:

Please Complete for the Past 12 Months Only

Sex: Male ☐ Female ☐

Ethnicity: Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Indian ☐

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you	☐	☐	☐	☐	☐
2. Insult or talk down to you	☐	☐	☐	☐	☐
3. Threaten you with harm	☐	☐	☐	☐	☐
4. Scream or curse at you	☐	☐	☐	☐	☐
	1	2	3	4	5
Total Score:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Each item is scored from 1-5. Range between 4-20. A score greater than 10 signify that you are at risk of domestic violence abuse, and should seek counseling or help from a domestic violence resource center such as the following:

Help in Los Angeles County (free, confidential, 24 hours a day):

LA County Domestic Violence Hotline: 1-800-978-3600

National Domestic Violence Hotline: 1-800-799-SAFE (7233), or text START to 88788

If you are in danger right now, call 911.

For more information, call **1.800.4BAYLOR** or visit us online at **BaylorHealth.com/DallasTrauma**.





California Adult Tuberculosis Risk Assessment (>18 years old)



Despite being preventable, tuberculosis (TB) disease continues to cause significant suffering and death in the state of California. Even with modern treatments, more than [1 in 6 Californians with TB die](https://www.cdc.gov/tb/data/) (bit.ly/cdc_tbca_data). TB is also a health disparity in California, with a disproportionate impact on people born outside the United States. **Identifying and treating persons with latent TB infection (LTBI) is the most promising tool to prevent TB disease.**

- Use this tool to identify asymptomatic adults for LTBI testing.
- Do not treat for LTBI until active TB disease has been excluded.
- A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

If a patient has symptoms of TB disease, including cough (for more than 2 weeks), fevers, night sweats, unexplained weight loss, or an abnormal chest x-ray consistent with TB disease, they should undergo further workup. **Contact your [local TB control program](https://www.ctca.org/locations.html)** if there is suspicion for active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

Only repeat TB testing if there is a new risk factor since last screening

☐ **Birth, travel, or residence** for at least 1 month, or frequent border crossing in a country with an elevated TB rate*

Interferon Gamma Release Assay (IGRA) is preferred over Tuberculin Skin Test (TST), especially for non-U.S.-born persons

☐ **Immunosuppression**, current or planned

HIV infection, organ transplant recipient, treated with biologic agents including TNF-alpha antagonist (e.g., infliximab, adalimumab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

☐ **Homelessness or incarceration**, current or past

Persons experiencing homelessness or residing in high-risk congregate settings including homeless shelter or correctional facility during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is excluded.

☐ **None**; no TB testing is indicated at this time.

Provider:

Assessment Date:

Patient Name:

Date of Birth:

(Place sticker here if applicable)

For more information about using this tool and for the most current version, go the [TB Risk Assessment page](https://cdph.ca.gov/tbriskassessment) (cdph.ca.gov/tbriskassessment).

Patient Health Questionnaire (PHQ-9)

Name:

Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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

For office coding: Total Score = + +

Total Score

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



ADVANCE DIRECTIVE, PRIVACY AND CONSENT FOR TREATMENT

Cardin HealthCare | 2880 Atlantic Ave, Suite 110 & 210, Long Beach, CA 90806
Phone (562) 424-4404 | Fax (562) 424-4770

PLEASE READ AND SIGN

Patient Name (first, last) *	Date of Birth (MM/DD/YYYY) *

ADVANCE DIRECTIVE

- ☐ I have an advance directive and will provide a copy.
- ☐ I have received information and instructions about advance directives.
- ☐ I decline advance directive information at this time.

I understand that I may update my advance directive at any time and provide a copy to Cardin HealthCare for my medical record.

PRIVACY PRACTICES (HIPAA)

I, the patient named above, acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices from Cardin HealthCare, Inc. I understand that this notice explains how my health information may be used and disclosed, and outlines my rights under HIPAA.

GENERAL CONSENT FOR TREATMENT

I, the patient named above, hereby request and consent to medical evaluation, diagnostic procedures (including X-rays and lab work), and treatment as deemed necessary and advisable by the professional staff of Cardin HealthCare, Inc. I understand that this consent applies to routine healthcare services and does not include procedures that require a separate, specific consent form.

Patient / Guardian Signature *	Date (MM/DD/YYYY) *

- ☐ By checking this box and typing my first and last name above, I acknowledge that this will serve as my legal signature on this form.

If signed by someone other than the patient: name and relationship

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