



5860 Ranch Lake Blvd. STE 200
Bradenton, FL 34202
(941) 202-3888
allcarecomplete.com

Please bring the following to your first appointment:

1. Paperwork completely filled out. If it does not apply to you, please put N/A.
2. All medications and supplements that you take in the original containers.
3. List of all doctors you may have seen in the past two years. Please include name and phone number so we may request records.
4. Please provide us with the name and phone number of your local pharmacy.
5. Your current insurance card, we need to update this information yearly.

Thank you,
The Physicians and Staff of AllCare Complete

**In order to properly thank your friends and acquaintances,
please, check all that apply:**

How Did You Hear About Us?

- Friend, or Relative _____ Name
- Letter or postcard
- Newspaper Ad
- Online Advertisement
- Medicare.gov
- Insurance Agent _____ Name
- Billboard
- TV or Radio Ad
- Community Newsletter

If you are a Medicare member, how did you enroll?

- Agent Online Educational Talk Telephone Called Medicare

If you enrolled with an agent. What is his/her name? _____

Welcome to Allcare Complete. If you need any assistance, please let the receptionist know.

Patient _____
Last Name First Name Middle Initial

SS# _____ Birth date _____

Home Phone # _____ Cell # _____

Street Address _____

City _____

State _____ Zip _____

Sex M F Age _____ Significant other Yes No Name: _____

Do you have any specialist appointments scheduled? Yes No
Where & When: _____

Prior Doctor and Phone Number:

Insurance:

Office Use Only: Availity Yes No | DL or ID scanned Yes No | Medical Records Requested Yes No

Labs: _____ Dr: _____

Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give AllCare Complete consent to perform medical treatment.

Prescription Renewal Policy

AllCare Complete physicians are available for emergencies 24 hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with a Medical Assistant during normal business hours of Monday thru Friday.

Insurance Authorization, Assignment and Guarantee of Payment

I request that payment of authorized Medicare / Other Insurance company benefits be made on my behalf to AllCare Complete for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration a healthcare administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permitted copy of this authorization to be used in place of the original comma and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security act and 31 U.S.C. 3801 – 3812 Provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to AllCare Complete for as long as I continue to receive services from them. If I were to receive any checks/payments intended as a payment for services rendered by AllCare Complete from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to AllCare Complete.

I understand that I am responsible for payment of all charges and fees to AllCare Complete that they are entitled to collect that they're not paid for by Medicare or other insurance.

Patient Name Printed

Date of Birth

Patient Signature

Date

Patient authorization for use and disclosure of protected health information (PHI) for purposes requested by the practice. (HIPAA Release of information)

Name: _____ (Please Print)

Date of Birth: ____/____/____

By signing this authorization, I authorize AllCare Complete to release/ disclose my medical information, medical history; progress notes with diagnosis; laboratory data; imaging studies and claims information. "Only as permitted or required by Federal or State Law", we may use your protected healthcare information to do the following:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: Referrals to or consultation with, other health care professionals, laboratories, hospitals etc.) or to others as may be required by law or a court order concerning your treatment, payment and or healthcare.
• To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care or treatment.
• To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individuals for payment of our services and treatment we provide for you.
• To discuss your healthcare payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments.
• To leave appointment reminders or other minimum necessary information related to your health care or health care payments on your answering machine, mobile voicemail or text mail, email or with a household family member.

- [] Check here if you do not want us to leave messages on your answering machine or with a household family member.
[] Check here if you do not want us to leave a voice/text message on your mobile device.
[] Check here if you are authorized to send your health care information by email (please understand the email may be an unsecured medium of transmission and is potentially accessible by others). In addition to checking the box, we reserve the right to require you to authorize in reading the transmission of your health care information to you by unsecured email.

• You may request a copy of and you have the right to read our notice of patient privacy practices prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

This information may be released to:

[] My Spouse/Partner _____
Name(s) Phone #

[] My Child(ren) _____
Name(s) Phone #

[] Other _____
Name(s) Phone #

[] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to: AllCare Complete 5860 Ranch Lake Blvd. STE 200, Bradenton, FL 34202. This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from AllCare Complete. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed By: _____
Signature of Patient or Legal Guardian

Date ____/____/____

AllCare Complete Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, our physicians and staff have the necessary medical and PHI to provide the highest quality of medical care possible. Our facility will always protect the confidentiality of the PHI of our patients to the highest degree possible. Our patients should not be afraid to provide information to our practice, its physicians and staff for purposes of treatment, payment and health care operations (TPO).

To that end, our practice, its physicians and our staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patients covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us to not to do so.
- Recognize that PHI collected about the patients must be accurate, timely, complete and available when needed.
- Our practice and its physicians and staff will implement reasonable measure to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice, its physicians and staff respect the patient's individual dignity at all times. Our practice, its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential information. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not disclose PHI data unless the patient has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. This may generate a bill according to Rule 64B8-10.003, Florida Administrative Code. In addition, patients have a right to request an amendment to his/her medical record if they believe his/her information is inaccurate or incomplete.
- Permit our patient access to their medical records when their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site health care professional review the patient's appeal,
- Provide the patient an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rules. We will provide this list to the patient upon request, as long as the request is in writing.
- All physicians and staff in our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, in accordance with our practice rules and regulations. Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy. As always, the privacy policy will be made available to patients upon request.

Effective 01.01.2022

**RECEIPT OF NOTICE OF PRIVACY PRACTICE
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of AllCare Complete's
Print Patient Name
privacy practice notice.

Signature of Patient

Date

Release of Medical Information

I, _____, with a date of birth, _____, give my permission for
 (Patient name) (Patient's DOB)
 _____ to give my medical records (as described) to the above referenced doctor
 (Doctor's or hospital name that has records)
 and /or organization so that he/she can better understand my condition and continuity of my healthcare.

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

(Please Initial ALL Lines)

- _____ My mental health,
- _____ Transmittable disease I may have like HIV/AIDS,
- _____ Genetic records, and/or
- _____ Drug and alcohol records.

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This form is only good for 3 months from the date I sign it.

Types of records we are requesting

- | | |
|---|---|
| <input type="checkbox"/> Any and all types of records you have for this patient | <input type="checkbox"/> Hospital Progress Notes Radiology Reports |
| <input type="checkbox"/> Doctor visit notes Doctors orders | <input type="checkbox"/> Operation or procedure notes Consultations |
| <input type="checkbox"/> Emergency Room notes Nurses notes | <input type="checkbox"/> Clinic notes Other |
| <input type="checkbox"/> Urgent care notes Discharge Summary | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> History and physical Lab reports | |

Patient's Full Name _____
(Please Print)

Patient's Social Security Number _____ - _____ - _____ Date Of Birth: ____/____/____

Patient's Signature _____ Date ____/____/____

Authorized Representative's Signature _____ Date ____/____/____

Relationship of Authorized Representative _____

For MEDICARE ADVANTAGE Patients ONLY

Understanding your insurance and the referral process:

If the insurance plan you have selected is a HMO/managed care plan:

1. Your Primary Care Physician (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and wellbeing.
2. While your Primary Care Provider (PCP) can provide most of your care, if you do need a specialist your PCP manages the care you receive from these healthcare specialists within the network.
3. Your Primary Care Physician (PCP) needs to issue a referral for you before you see any specialist.
4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.
5. Within the HMO there are a select number of Providers that have demonstrated outstanding care and improved outcomes.
6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.
7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

Thank you for joining our practice!

Signature

Date

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| | | |
|--|--|--|
| Primary Language: | | Interpreter Needed? <input type="checkbox"/> Y <input type="checkbox"/> N |
| Name (Last, First, M.I.): <input type="checkbox"/> M <input type="checkbox"/> F | | DOB: |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | |
| Previous or referring doctor: | | Date of last physical exam: |
| EMERGENCY CONTACT: | | Contact #: |
| Can we send you our newsletter? <input type="checkbox"/> Y <input type="checkbox"/> N | | Email: |
| Can you afford your medicine? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Potential referral to assistance program _____ | | |

PERSONAL HEALTH HISTORY

| | | | | |
|--|------------------------------------|------------------------------------|---|-----------------------------------|
| Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio | | | | |
| Immunizations and dates: | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Influenza | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Shingles |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> | |

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

| | | |
|---|--|---|
| Amputation <input type="checkbox"/> Yes <input type="checkbox"/> No | CVA/TIA <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Breakdown <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol Overuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/COPD <input type="checkbox"/> Yes <input type="checkbox"/> No | Ostomies <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies (Other than Medications) <input type="checkbox"/> Yes <input type="checkbox"/> No | Falls <input type="checkbox"/> Yes <input type="checkbox"/> No | Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/ MI <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Heart Disease (CHF/CAD) <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location: | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Arrhythmias <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No | | Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

OPERATIONS, SERIOUS INJURIES, HOSPITALIZATIONS AND DIAGNOSTIC TESTS/EXAMS (PLEASE LIST REASONS AND APPROXIMATE YEAR)

| | | |
|--|--|---------------|
| | | |
| | | |
| | | |
| | | OTHER: |

| |
|---|
| Durable Medical Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Wheelchair <input type="checkbox"/> Oxygen <input type="checkbox"/> Walker/Cane <input type="checkbox"/> Nebulizer <input type="checkbox"/> CPAP/BIPAP <input type="checkbox"/> Other: _____ |
|---|

Provider Signature _____ **Date** _____

FAMILY HISTORY-HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING AND THEIR RELATIONSHIP

| ILLNESS | YES/NO | | RELATIONSHIP |
|--------------------------|------------------------------|-----------------------------|--------------|
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Bleeding Tendency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Colitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Congenital Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

| ILLNESS | YES/NO | | RELATIONSHIP |
|---------------------|------------------------------|-----------------------------|--------------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Intestinal Polyps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Leukemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Nervous Breakdown | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Stomach Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Suicide | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Other: | | | |

PREVENTATIVE SERVICE HISTORY-HAS THE FOLLOWING TESTING: NEVER BEEN DONE (NO), OR, HAS BEEN DONE (YES). IF YES, YOUR BEST ESTIMATE OF THE MONTH/YEAR THE TEST WAS PERFORMED AND THE RESULT.

| Preventative Service | YES/NO | | Month/Year | Result |
|---|------------------------------|-----------------------------|------------|--------|
| Bone Mass Measurement (Bone Density) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Bloodwork | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Colorectal Cancer Screening: Colonoscopy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Colorectal Cancer Screening: Fecal Occult Blood Test (Stool Card) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Vision Screening: Eye Exam | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Female Screening: PAP & Pelvic Examination | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Female Screening: Mammogram | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Male Screening: PSA – Prostate Specific Antigen | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Other: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | |
|------------------------|---|--|---|--|
| Exercise | <input type="checkbox"/> Sedentary (No exercise) | <input type="checkbox"/> Mild exercise | <input type="checkbox"/> Occasional exercise | <input type="checkbox"/> Regular vigorous exercise |
| Diet | Are you dieting? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, are you on a physician prescribed medical diet? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tobacco | Do you use or have used tobacco? If yes, quit date: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes – pks./day | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day | <input type="checkbox"/> Cigars - #/day |
| Alcohol/Drugs | Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N - #/day | | Do you use the following? <input type="checkbox"/> CBD <input type="checkbox"/> Marijuana | |
| | Do you use drugs? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cocaine <input type="checkbox"/> Meth <input type="checkbox"/> LSD <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> Other _____ | | | |
| Sex | Are you sexually active? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Any discomfort with intercourse? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Personal Safety | Do you live alone? [] Apartment [] Mobile Home [] House [] Asst. Living [] Ind. Living | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have frequent falls? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have vision or hearing loss? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have problems with speech? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have an Advance Directive and/or Living Will? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Provider Signature _____ **Date** _____

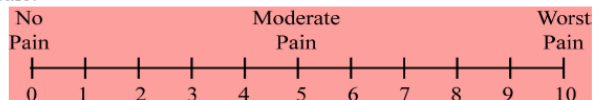
| MINI NUTRITIONAL HEALTH ASSESSMENT (MNA) | | | |
|---|------|---------|---------|
| Sex (Circle One): Male Female | Age: | Weight: | Height: |
| A. Has food intake declined over the last 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 0 = Severe decrease in food intake 1= Moderate Decrease in food intake 2= No decreases in food intake | | | = |
| B. Weight loss during the last 3 months? 0= Weight loss greater than 6.6lbs (3kg) 1= Do not know 3= Weight loss between 2.2-6.6lbs (1-3kg) 3= No Weight loss | | | = |
| C. Mobility 0= Bed or chair bound 1= Able to get out of bed/chair but do not go out 2= go out | | | = |
| D. Suffered Stress in the past 3 months? 0= Yes 2 =No | | | = |
| E. Neuropsychological problems 0= Severe Dementia or Depression 1= Mild Dementia 2= No psychological problems | | | = |
| For Physician Use Only | | | |
| F1. Body Mass index (BMI) (Weight in KG/Height in M ²). 0= BMI less than 19. *If BMI is not available replace question F1 with F2. 1= BMI >19 less than 21 Do not answer F2 if F1 is already answered. 2= BMI >21 less than 23 3= BMI 23 or greater | | | = |
| F2. Calf Circumference (CC) in cm. 0= CC less than 31 1= CC 31 or greater | | | = |
| Screening Score (Max 14 points) 12-14 = Normal Nutritional Status 8-11 = At Risk of Malnutrition 0-7 = Malnourished | | | |

Functional Status Assessment: Activities of Daily Living (ADL) and Activities of Instrumental Living (IADL):
Please check the appropriate category that best fits you:

| Activity | Independently | With Assistance | Dependent |
|------------------------------|---------------|-----------------|-----------|
| Bathing | | | |
| Dressing | | | |
| Eating | | | |
| In and out of Chairs | | | |
| Toileting | | | |
| Walking | | | |
| Taking Medication | | | |
| Driving | | | |
| Use of Public Transportation | | | |
| Use Phone | | | |
| Meal Prep | | | |
| Housework | | | |
| Handling Finances | | | |

If needed, who helps you with your activities: _____

Pain Screening: How would you rate your pain on a scale from 0-10 or use the scale:



Pain 0 to 10: _____

Location: _____

Quality (Sharp, Dull, etc...): _____

Provider Signature _____ **Date** _____

Patient Health Questionnaire

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

| | 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 | 0 | 1 | 2 | 3 |

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

| | | |
|---|----------------------|-------|
| <p>10. If you checked off <i>any problems</i>, 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?</p> | Not difficult at all | _____ |
| | Somewhat difficult | _____ |
| | Very difficult | _____ |
| | Extremely difficult | _____ |

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
 Several days (#) _____ x 1 = _____
 More than half the days (#) _____ x 2 = _____
 Nearly every day (#) _____ x 3 = _____

Total score: _____

| Interpreting PHQ-9 Scores | | Score | Actions Based on PH9 Score |
|------------------------------|-------|----------|---|
| | | | Action |
| Minimal depression | 0-4 | < 4 | The score suggests the patient may not need depression treatment |
| Mild depression | 5-9 | | |
| Moderate depression | 10-14 | > 5 - 14 | Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment |
| Moderately severe depression | 15-19 | | |
| Severe depression | 20-27 | > 15 | Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment. |

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/