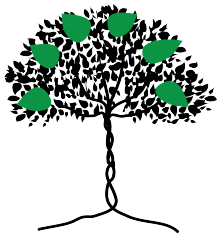

HARBOR CARE HEALTH & WELLNESS CENTER

Patient Intake Form

Please print clearly. Please ask for assistance in completing this form if needed.

Today date: _____

Patient Full Name: _____ **Date Of Birth:** _____

Street: _____ **City:** _____ **Zip Code:** _____

Primary Phone: (____) _____ **Cell Home Work** **Other Phone #: (____)** _____

Ok to leave a message? Yes No **Email Address:** _____

Gender: ◯ Female ◯ Male ◯ Transgender **Marital Status: ◯ Single ◯ Married ◯ Other:** _____

If the patient is under 18 years old please complete this section:

Parent/Guardian Name: _____ **Date of Birth:** _____
Relationship to Patient: _____
Address if different: _____ **City:** _____ **Zip Code:** _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Disabled ◯ Retired ◯ Child/Student

Employer Name: _____Address:_____ Occupation: _____

Do you have Health Insurance? Yes NO

Please present your Insurance Card(s) at EVERY visit

Primary Insurance Carrier: _____

Name of Policy Holder: _____ **DOB:** _____

Insurance ID #_____

Relationship to patient if other: _____

Who does your insurance company list as your Primary Care Provider? _____

Secondary Insurance Carrier: _____

Name of Policy Holder: _____ **DOB:** _____

Insurance ID #_____

Relationship to patient if other: _____

If you DO NOT HAVE HEALTH INSURANCE:

Please request a Sliding Fee Discount application

and meet with our Certified Navigators to assist with insurance enrollment.

Please Circle All That Apply:

- **Is your Primary Language English?** Yes No **Do you need an interpreter?** Yes No
- **Are you Deaf or hard of hearing**? Yes No **Do you need sign language interpreter**? Yes No
- **What is your highest level of education?**

  Grade School Some High School High School Graduate GED Some College / Degree
- **Have you ever served in the military?** Yes No
- **What is your discharge Status?** Honorable General Dishonorable

Do you have a permanent address? Yes No **Do you receive Section 8?** Yes No

If no permanent address where did you spend your night?

Shelter	Unsheltered	Transitional Housing	Doubling Up	Agency/Facilities
Ash Street	Street	Veterans First	Couch Surfing	Hospital
Kinsley Street	Park	Keystone/Cynthia Day	Family	Jail Prison
Maple Street	Tent	Mary's House	Friends	Other_____
Rescue Mission		Safe Haven/YMCA	Parents Home	

Some of our grants ask us to report on the race and ethnicity of the people we serve.
*Your information **will not be shared** with your name.*
*It will only be shared as a **summary** of all the people we serve. Responses to these questions are optional.*

Race:

- White ● Black/African American
- Asian ● Native Hawaiian
- Multi-Racial ● Other Pacific Islander
- American Indian/Alaskan Native
- I do not want to respond

Ethnicity:

- Hispanic/Latino ●Non-Hispanic/Latino
- I do not want to respond

Sexual orientation:

- *Heterosexual* ● *Bisexual*
- *Homosexual* ●*Other*_____
- *Choose not to disclose*

How did you hear about us?

- Employee ● Hospital
- Friend ● Family
- Walk-in ● Keystone
- Hospital ● School
- Insurance Carrier ● Other Provider
- Website
- Other_____

Family Household Size:
_____

Estimated Monthly/Annual Household Income:
_____

Emergency Contact:

Name: _____Relation_____
Address: _____Phone Number: _____

Name: _____ **DOB:** _____

Medical History Form

Family and Health History: *Please enter Y / N or U for unknown*

	Self	Mother	Father	Grandparents	Brother/Sister	Aunts/Uncles
Alcohol/Drug Abuse						
Anemia						
Asthma or Bronchitis						
Behavioral Health Emotional/Nervous/Mental						
Bladder/Kidney Disease or Problems						
Broken Bones/Fracture						
Cancer or Tumors						
Diabetes						
Epilepsy or Seizures/Blackouts						
Eye or Vision Problems						
Gyn Problems or Miscarriages						
Head Injury						
High Blood Pressure						
Heart Disease (stroke, heart attack)						
HIV/AIDS						
Liver Disease/Hepatitis						
Pneumonia						
Skin Problems						
Stomach/bowels Problem						
Thyroid Problems						
Teeth Problems						
Tuberculosis (TB) or TB exposure						

Are you allergic to any food or medications? Yes or No

Please List All Allergies:

Please list any medications that you are prescribed by a doctor or taking over the counter:

Name of medication	Dose	How Often	Who Prescribed it?

Medical Questionnaire

Have you ever been hospitalized? Yes or No

If yes please explain_____

Where did you last receive Health related services?

_____

When is the last time you had went to the dentist? _____

Do you have pain today? Yes No If yes on a scale 0 to 10 (10 being horrible) how bad is your pain today?

_____

When was your last Tetanus shot? _____ Other Vaccines: _____

Are you sexually active? Yes No With: Men Women Both Number of partners in last year _____

Do you use condoms to protect against STD's? Yes No

Have you been tested for HIV? Yes No *Results*: Negative Positive

Have you ever been tested for Hepatitis? Yes No *Results*: Negative Positive

Have you ever had an STD? Yes No When? _____ What? _____

Are you currently concerned about your safety at home or with others? Yes No

Have you experienced abuse in the past? Yes or No *Type of abuse:* Emotional Physical Sexual From who?

_____

Do you use Tobacco Products? Yes No

If yes how much per day? _____ Would you like help to quit? Yes No

Do you use Drugs or Alcohol? If yes drug type _____ How often_____

When did you last use? _____ Have you ever gone through withdrawals? Yes or No When? _____

Have you ever been arrested or in prison? Yes No If yes when? _____

Have you ever detoxed? Yes No How long have you been substance free? _____

Have you had any other medical condition that has not been listed?

_____

If you are over 65 years, have you fallen in the past 12 months? Yes or No

In our efforts to coordinate care do you receive services from other agencies? If so please provide name of person(s) you work with._____

_____

If you are a female:

Are you on birth control? Yes No

Date of last menstrual period? _____ Date of last PAP? _____Was it abnormal? Yes NO

Have you ever had a mammogram? Yes No If yes when and result? _____

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Harbor Homes Inc.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 45 High Street Nashua, NH 03060.

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, Healthcare surrogate, etc.)

☐ **Patient/Client Refuses to Acknowledge Receipt:**

Signature of Staff Member **Date**

Appropriate Clinic Conduct Policy

Harbor Care Health and Wellness Center must maintain a safe and comfortable atmosphere for all staff and patients. Anyone who conducts themselves in a manner considered to be inappropriate (outlined below) will be informed of our concern and asked to sign a patient agreement. Patients who refuse, or who break the agreement, may be discharged from our services. A report of a staff acting inappropriately will be investigated and may result in employment termination.

Inappropriate Conduct:

Threatening verbal or written statements
Threats of bodily harm
Violence toward any staff or patient
Throwing objects or hitting, slamming walls, doors etc.
The presence of any weapon in the building

Readmission:

Patient who have been discharged for these reasons can only be re-admitted through the Medical Director's permission in consultation of the VP, of Operations. The medical Director will be to consider all viewpoints in his/her deliberation.
I have read the above policy:

_____ _____

Signature of patient/Guardian **Date**

_____ _____

Signature of Staff/Witness **Date**

No Show of Appointments, Late and Cancelations

Policy: If a patient no shows their appointment (as a new patient) or has three appointment no shows in any consecutive 3 months, then that patient must be placed on a same day status for three consecutive appointments. In regards to late arrival for appointments, patients will be given an arrival time for their appointment 15 minutes in advance of the actual appointment time. If a patient then arrives after the actual scheduled appointment time, there is no guarantee we will be able to see them. The provider will make the decision at the time if the patient can be accommodated. Specifically, there is no guarantee the patient can be seen if they are more than:

1. 5 minutes late for a short appointment
2. 10 minutes late for a long appointment
3. Late (at all) for any procedure.

If a patient cancels excessively, the provider may, at their discretion, choose to put the patient on a same day status to improve their compliance with care, or to deny them services if necessary.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand I am financially responsible for all the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government health care program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize Harbor Care Health and Wellness Center to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make direct payments to Harbor Care Health and Wellness Center in response to these bills or claims.

X_____ Date_____

Signature

Received:

- Patient Bill Of Rights Signature: _____ Date:_____
- Consent to treatment Signature: _____ Date: _____
- Appointment Policy Signature: _____ Date_____

Employee Signature of witness _____ Date _____

SBIRT AUDIT Forms (English and Spanish)

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	Zero to two	Three or four	Five or six	Seven to nine	Ten 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
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

I	II	III	IV
0	8	16	20

PHQ-2

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 everyday
1.Little or no pleasure in doing things	0	1	2	3
2.Feeling down, depressed or hopeless	0	1	2	3

DAST-10

These questions refer to the **past 12 months**. Circle the best response:

1. Have you used drufs 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 always able to stop using drugs when you want to? Yes No
4. Have you 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 had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? Yes No