Options Medical
Blair T. Butterfield, D.O.

PATIENT DATA SHEET / INSURANCE VERIFICATION

PATIENT INFORMATION										
Name (Last, First Middle)				Date of Birth		SSN		Preferred Language		
Marital Satus	Single	Divorced	Separated	Sex	Female	Employment	Full Time	Retired	Unemployed	
	Married	Partner			Male		Part Time	Disabled	Student	
Race	American Indian / Alaskan		Asian		Hawaiian / Pacific Islander					
	White		Black / African American		Hispanic					
Address				City		State		Zip		
Home Phone				Cell Phone				Work Phone		
Occupation				E-Mail Address				Other Phone		
Employer				Employer Address						
Emergency Contact						Phone Number			Relationship to Patient	
Who referred you to our office?				Parent/Guardian (if patient is a minor)						

PRIMARY INSURANCE **Insurance Holders Information** **Self _____ Spouse _____ Parent _____**				
Insurance Name / Plan			Policy/Claim/Member #	
Group #		Employer Name		
Name (Last, First Middle)	Date of Birth	SSN		Sex
Address	City	State	Zip	
Cell Phone	Homel Phone	Work Phone		

SECONDARY INSURANCE **Insurance Holders Information** **Self _____ Spouse _____ Parent _____**				
Insurance Name / Network			Policy/Claim/Member #	
Group #		Employer Name		
Name (Last, First Middle)	Date of Birth	SSN		Sex
Address	City	State	Zip	
Cell Phone	Home Phone	Work Phone		

Signature: **Date:**

Notice of Privacy Practices

Blair T. Butterfield, D.O., P.C. dba Options Medical

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis and customer service. An example of this would be new patient survey cards.

The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations we will do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone, e-mail, text message or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following uses and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of November 5, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at (480)751-3091 for more information or in person or in writing at 4135 S. Power Rd., Suite 129 Mesa, AZ 85212.

Options Medical
Blair T. Butterfield, D.O., P.C.
4135 S. Power Rd. Ste 129
Mesa, AZ 85212

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Options Medical P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare options (TPO). Please request a copy of Options Medicals' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Options Medical, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by requesting a copy through the office or by forwarding a written request to the Privacy Officer at 4135 S. Power Rd. Ste 129, Mesa, AZ 85212.

With my consent, Options Medical, P.C. may call my home or other designated location and may leave messages on voice mail or in person in reference to any items that assist our office in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results.

I wish to be contacted in the following manner (check all that apply)

☐ **Home Phone Number** _____

☐ O.K. to leave message with detailed information

☐ O. K. to leave detailed message with person

☐ Leave message with call back number only

☐ **Cell Phone Number** _____

☐ O. K. to leave message with detailed information

☐ Leave message with call back number only

☐ **Persons we are NOT able to give PHI**

_____

_____

☐ **Written Communication**

☐ O. K. to mail to my home address

☐ O. K. to mail to my work office

☐ O. K. to fax this number _____

☐ Persons we are able to give detailed information to

_____

_____

I have the right to request that Options Medical restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Options Medical, P. C. to use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. If you do not sign this consent, Options Medical, P. C. may decline to provide treatment to me.

Signature of Patient / Legal Guardian Date

Print Name of Patient

Options Medical
Blair T. Butterfield, D.O., P.C.
4135 S. Power Rd. Ste. 129
Mesa, AZ 85212

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent to **Blair T. Butterfield, D.O.** to provide medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.
(Patient's printed name)

Patient/Guardian/Responsible Party Signature _____ Date_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:

I authorize **Blair T. Butterfield, D.O.** to release to my insurance company any medical information necessary to process claims for treatment that I receive under their care in order to secure payment. I authorize payment of any insurance benefits for medical services be paid directly to Blair T. Butterfield, D.O., P.C..

Patient/Guardian/Responsible Party Signature _____Date _____

Privacy Practices: By initialing here, I acknowledge that I have received a copy of Blair T. Butterfield, D.O.'s Notice of Privacy Practices and have been provided an opportunity to review it.

_____
(initial here)

FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY:

Blair T. Butterfield, D.O. will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to Blair T. Butterfield, D.O., P.C..

Your insurance company requires us to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. If we do not collect these amounts, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. In the event that a check is returned for Non-Sufficient Funds, a $25.00 service fee will be charged to you.

_____
(initial here)

We have verified your medical benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received.

Please Note: Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any of the payments I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to court costs, collection agency fees and attorney fees.

Patient/Guardian/Responsible Party Signature_____ Date _____

healthcurrent
Imagine fully informed health

Options Medical
A New Concept in Family Health Care

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally-assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency.
Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through HealthCurrent. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information throughHealthCurrent.Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
   Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy."

Signature_____**Date**_____

Initial Health History

*Please help us provide you with the best quality care by filling out this form **completely***

Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Age: ____ Gender: ❑ Male ❑ Female

PERSONAL MEDICAL HISTORY	Now	Past	Never
1 Migraines or chronic headaches	❑	❑	❑
2 Stroke or transient ischemic attacks .	❑	❑	❑
3 Glaucoma or other eye disease	❑	❑	❑
4 Chronic hearing loss	❑	❑	❑
5 Thyroid or other endocrine disorder ..	❑	❑	❑
6 Heart disease or prior heart attack ...	❑	❑	❑
7 Atrial fibrillation or heart arrhythmia	❑	❑	❑
8 High blood pressure or cholesterol? ..	❑	❑	❑
9 Blood clot or clotting disorder	❑	❑	❑
10 Asthma, COPD or lung problems	❑	❑	❑
11 Allergies, sinus or skin problems	❑	❑	❑
12 Sleep apnea or sleep disorder	❑	❑	❑
13 Ulcers, reflux disease or IBS	❑	❑	❑
14 Diabetes or hypoglycemia	❑	❑	❑
15 Kidney disease or kidney stones	❑	❑	❑
16 Uterine or ovarian problems	❑	❑	❑
17 Hepatitis B or C or HIV	❑	❑	❑
18 Cancer or tumor	❑	❑	❑
19 Spine or disc disorder	❑	❑	❑
20 Osteoporosis or osteopenia	❑	❑	❑
21 Arthritis or autoimmune disorder	❑	❑	❑
22 Anxiety, depression or psych disorder	❑	❑	❑

Please list any **specialists** you are currently seeing:

23 _____

SURGICAL HISTORY ❑ None

24 ❑ Tonsils	28 ❑ Gall Bladder	32 ❑ Hysterectomy
25 ❑ Thyroid	29 ❑ Appendix	33 ❑ Joint replacement
26 ❑ Heart	30 ❑ Cosmetic	
27 ❑ Spine	31 ❑ Biopsy	34 ❑ _____

FAMILY HISTORY 35 ❑ None

Mark with "X"		Dad	Mom	Bro.	Sis.	Other - who?
Cancer	Breast					
	Colon					
	Prostate					
	Skin					
	Other					
Heart disease						
M.I. before 50						
Stroke						
Diabetes						
Osteoporosis						
Asthma						

Please list any other chronic conditions

_____

_____

_____

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PRESCRIPTIONS ❑ None

Medication Name	Dose in mg, etc	# in AM	# at Noon	# at Night	Reason for medication	How long?	additional information

OVER THE COUNTER (including vitamins, herbs, minerals) ❑ None

Product Name	Dose in mg, etc	Total # per Day	additional information

DRUG ALLERGIES ❑ None

Medication Name	Reaction

TOBACCO ❑ Never ❑ Past ❑ Present ❑ Lived w/ smoker ❑ cigarettes ❑ cigars ❑ pipe ❑ chev

Packs/day: __ # of years: ___ Year quit: _____ Plan to quit? ❑ now ❑ 6 mos ❑ sometime ❑ never

CAFFEINATED BEVERAGES (coffee, tea, soda, energy drink) Daily: ❑ 0 ❑ 1-3 ❑ 4-7 ❑ 7+

ALCOHOL

❑ None
❑ Rarely
❑ Monthly
❑ Weekly
❑ Daily
❑ Recovering alcoholic

If you drink, have you ever felt:

❑ you should reduce the amount you drink?
❑ annoyed by people nagging you to stop?
❑ guilty about your drinking?
❑ the need to drink 1st thing in AM to steady your nerves or get rid of a hangover?

RECREATIONAL DRUGS

	Now	Past	Never
Marijuana	❑	❑	❑
Stimulants (Speed, etc)	❑	❑	❑
Inhalants	❑	❑	❑
Methamphetamine	❑	❑	❑
IV drugs (heroin, etc)	❑	❑	❑

DIETARY

How much is in your diet?	none	few	some	a lot
Grains and starches	❑	❑	❑	❑
Fruits and vegetables	❑	❑	❑	❑
Dairy products	❑	❑	❑	❑
Meats	❑	❑	❑	❑
Fish	❑	❑	❑	❑
Sweets and junk food	❑	❑	❑	❑
Fats and fried foods	❑	❑	❑	❑

WATER

How many glasses of water do you drink daily?

❑ 0 ❑ 1-5 ❑ 6-10 ❑ 10+

EXERCISE ❑ none

Activity: _____

Days per week _____ for _____ minutes at a time

Exertion: ❑ mild ❑ moderate ❑ strenuous

PREVENTION

		Yes	No
36	Cholesterol checked in the past 5 years?	❑	❑
37	Tetanus shot in the past 10 years?	❑	❑
38	Do you always wear your seat belt?	❑	❑
39	Working smoke detector in your home?	❑	❑
40	Do you have firearms in your home?	❑	❑
41	Do you brush your teeth daily?	❑	❑
42	Dental check-up in the past year?	❑	❑
43	Women: PAP smear in past year?	❑	❑
44	if > 40, Mammogram in past year?	❑	❑
45	Men: if > 40, Prostate exam in past year?	❑	❑
46	if > 50: Bone density scan in past 2 years?	❑	❑
47	Colonoscopy in past 10 years?	❑	❑
48	Pneumonia shot in past 10 years?	❑	❑

# of sexual partners in past 12 months? ___ lifetime? ___

SYSTEMS REVIEW *(Present symptoms)*

		Yes	No
49	Headaches, dizziness or lightheadedness	❑	❑
50	Sudden change in vision in the past month	❑	❑
51	Neck pain or swollen glands or lymph nodes	❑	❑
52	Chest pain, shortness of breath, wheezing	❑	❑
53	Chronic or recurrent cough	❑	❑
54	Heartburn, stomach or abdominal pain	❑	❑
55	Change in size or firmness of stools	❑	❑
56	Change in urine stream strength or flow rate	❑	❑
57	Excessive urination during day or night	❑	❑
58	Blood in urine or stool	❑	❑
59	Menstrual problems, irregularity or pelvic pain	❑	❑
60	Problems with sexual desire or performance	❑	❑
61	Bothersome joint or back pains	❑	❑
62	Change in the size or color of a mole	❑	❑
63	Sleeping problems in past month	❑	❑
64	Feeling depressed or hopeless in past month	❑	❑
65	Problems with falling or doing routine tasks	❑	❑
66	Weak, numb or inability to talk in past month	❑	❑

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Please list any additional health concerns that you have:

_____

_____

_____

Blair T. Butterfield, D.O. Date

HEALTH CARE DIRECTIVE (LIVING WILL)

I, _____ want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

SECTION 1:

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means (check all that apply):

- ☐ Unconscious (chronic coma or persistent vegetative state)
- ☐ Unable to communicate my needs
- ☐ Unable to recognize family or friends
- ☐ Total or near total dependence on others for care
- ☐ Other: _____

Check only one:

- ☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
- ☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTION 2: (You may leave this section blank.)

Some people do not want certain treatments under any circumstance, even if they might recover.

Check the treatments below that you do not want under any circumstances:

- ☐ Cardiopulmonary Resuscitation (CPR)
- ☐ Ventilation (breathing machine)
- ☐ Feeding tube
- ☐ Dialysis
- ☐ Other: _____

SECTION 3:

When I am near death, it is important to me that: _____

_____

_____

_____

(Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.)

BE SURE TO SIGN PAGE TWO OF THIS FORM

- If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.
- Take a copy of this with you whenever you go to the hospital or on a trip.
- You should review this form often.
- You can cancel or change this form at any time.

HEALTH CARE (MEDICAL) POWER OF ATTORNEY
WITH MENTAL HEALTH AUTHORITY

It is important to choose someone to make healthcare decisions for you when you cannot. **Tell the person (agent) you choose what you would want.** The person you choose has the right to make any decision to ensure that your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** in the line for the agent's name.

I, _____ , as principal, designate

_____ as my agent for all matters relating to my health (including mental health) and including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

_____ By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

Print agent ADDRESS and PHONE:

_____

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint:

_____ as my agent.

Print alternate agent ADDRESS and PHONE:

_____

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive forms

Please ask one person to witness your signature who is not related to you or financially connected to you or your estate.

Signature _____ Date _____

The above named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness _____ Date _____

This document may be notarized instead of witnessed.

On this _____day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public _____

FOR MORE INFORMATION CONTACT HEALTH CARE DECISIONS, (602) 222-2229 OR WWW.HCDECISIONS.ORG

Name: _____ DOB: _____ Today's Date: _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ❒ Yes ❒ No

Little interest or pleasure in doing things? ❒ Yes ❒ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by of the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, 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

For Office Use Only: Total Score

Providers signature: _____

Name:_____ DOB:_____ Today's Date:_____

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer"*	Not at all	Several days	More than 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 is 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

Column totals: Text ___ + ___ + ___ + ___

= 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**
☐	☐	☐	☐

Options Medical

A New Concept in Family Health Care

Please Bring to your Appointment

Picture ID i.e. Drivers License

Insurance Card

ALL Medications

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