Kindly return these completed forms at your next visit.

Today's Date________

Patient Name:____

Date of Birth: ____

Cell Phone Number: ____

Email: ____

Home Address: ____

____

Insurance Name:____

Insurance Member ID:____

Emergency Contact Name___________________________________

Cell phone number: ______________________

PLEASE COMPLETE THE INFORMATION BELOW AS BEST YOU CAN. RETURN TO THE FRONT DESK STAFF UPON CHECKING IN FOR YOUR APPOINTMENT. REMINDER: YOU WILL BE ASKED TO PRODUCE A URINE SAMPLE AT YOUR VISIT.

Name _______________________________________

Date of Birth ________________

Date of last mammogram ________

Date of last colonoscopy _________

Date of last DEXA________________

Date of last Colorguard___________

Date of last eye exam ____________

Dates last of Shingrix vaccine _________

Date of last Flu vaccine _____________

Date of last Pneumonia vaccine ________

Date of last Tetanus vaccine_________

Date(s) of COVID vaccine(s) _________

COVID vaccine manufacturer________

Please list **ALL** of the medications you are **CURRENTLY** taking, including **DOSAGE** amounts and the **TIME OF DAY** the medicine is taken. Include **OVER THE COUNTER** medicine such as aspirin and Tylenol, as well as any medicine prescribed by any of your other doctors and/or specialists.

Medication ____________________________Dosage/Frequency ________________________________

Medication ____________________________Dosage/Frequency ________________________________

Medication ____________________________Dosage/Frequency ________________________________

Medication ____________________________Dosage/Frequency ________________________________

Medication ____________________________Dosage/Frequency ________________________________

Please list **ALL** of the Specialist physicians that you are currently under the care of:

Physician Name/Specialty _______________________________ Phone Number __________________________

Physician Name/Specialty _______________________________ Phone Number __________________________

Physician Name/Specialty _______________________________ Phone Number___________________________

Physician Name/Specialty _______________________________ Phone Number___________________________

You may use the reverse side if you need additional space. Thank you.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________ **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 figety 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: ________

10. 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	________

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