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INTERNAL MEDICINE

PATIENT INFORMATION SHEET

Name: _____ SSN: _____
Age: _____ DOB: _____ Sex: _____

Address: _____ Zip: _____ City: _____ State: _____

Pharmacy Name and Address: _____ **Pharmacy Phone:** _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____ Contact Preference: Home / Cell / Work / Email (circle one)

Employer/School: _____ Full time / Part Time / Retired / Disabled / Student (circle one)

Employer/School Address: _____ Phone: _____

Patient Status (circle one): Married / Single / Divorced / Widow / Separated / Partner

How did you hear about us? _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Guarantor/Guardian Last Name: _____ First: _____ Middle Initial + Suffix: _____

DOB: _____ Guarantor Address: _____ Zip: _____ City: _____

State: _____ SSN: _____ Phone: _____ Work: _____

Employer: _____ Employer Address: _____

	Primary	**Secondary**
Insurance Company:		
Claims Address:		
City, State, Zip:		
Phone:		
ID/Policy #:		
Group/Plan #:		
Subscriber's DOB:	M or F	M or F
Name of Subscriber:		

REASON FOR VISIT _____

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CLINICAL HISTORY

Name: _____ DOB: _____ Age: _____ Marital Status: S M D W

Occupation: _____ Employer: _____ Birthplace: _____

Education: _____ Years High School: _____ Years College: _____ Years Post Grad Height: _____ Weight: _____

Date of Last Physical _____/_____/_____ Where was last physical performed: _____

List All Medications You Are Taking at the **Present Time**:

Medication	Dosage	Taken for:	Medication	Dosage	Taken for:

Medication allergies (if none, please write NKDA): _____

Other allergies: _____

Do you smoke? _____ If yes, how much and for how long? _____ Quit date, if former smoker? _____

Do you use alcohol? _____ If yes, how much and how often? _____

Do you drink caffeine? _____If yes, how much and how often?_____

Do you or have you ever taken sedatives?__If yes, how much and how often?_____

Do you or have you ever taken stimulants?___If yes, how much and how often?_____

Do you or have you ever used marijuana?___If yes, how much and how often?_____

Do you or have you ever used cocaine?___If yes, how much and how often?_____

Do you or have you ever used hallucinogens?___If yes, how much and how often?_____

Do you or have you ever used any other drugs or substances not listed? If yes, what and how often and how much?_____

Have you ever had a drug abuse problem? ___ Have you ever used IV drugs? ___ Have you ever been exposed to HIV?_____

Are you sexually active? _____ What is the sex of your partner? _____ Do you use protection? ___
If so what type? _____

Are there any guns or weapons in your house (specify whose and what type)? _____

Do you wear a seat belt? _____ Are there smoke detectors in your home? _____ Are there carbon monoxide detectors in your home? _____

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Where were you born and raised: _____ By whom: _____

Siblings: _____ History of any type of Abuse: _____

Schools attended and highest level of education: _____

Work History: _____

Current Financial Support: _____

Marital History: _____ Number of Children: _____ Legal / Military History: _____

Developmental History:

Birth Weight: _____ Special Ed: _____ Failed a Grade: _____ Current Grade and School: _____

MEDICAL HISTORY – HAVE YOU EVER HAD? Please circle YES or NO for all questions.

CHILDHOOD DISEASES

Measles	YES	NO
Mumps	YES	NO
Chicken Pox	YES	NO
Whooping Cough	YES	NO
Scarlet Fever	YES	NO
Rheumatic Fever	YES	NO

METABOLIC DISEASES

Diabetes	YES	NO
High Blood Pressure	YES	NO
Thyroid Disease	YES	NO
Osteoporosis	YES	NO
Other	YES	NO

PULMONARY DISEASES

Pneumonia	YES	NO
Asthma	YES	NO
COPD	YES	NO
Tuberculosis	YES	NO
Other	YES	NO

CNS/NEUROLOGICAL DISEASE

Stroke	YES	NO
Seizure	YES	NO
Other _____	YES	NO

CARDIAC DISEASES

Heart Attack	YES	NO
Angina	YES	NO
Heart Murmur	YES	NO
Arrhythmia	YES	NO
Valve Problems	YES	NO
Other	YES	NO

GI DISEASES

Ulcer	YES	NO
Gall Bladder	YES	NO
Hiatal Hernia	YES	NO
GI Bleed	YES	NO
Obstruction	YES	NO
Other	YES	NO

UROLOGIC DISEASES

UTI	YES	NO
Kidney Stone	YES	NO
Dialysis	YES	NO
Other	YES	NO

CANCER YES NO

If yes, location _____
Year Diagnosed _____
Reoccurrence YES NO
Current Treatment YES NO

INFECTIONS

After surgery	YES	NO
Venereal Disease	YES	NO
HIV (AIDS)	YES	NO
Osteomyelitis	YES	NO
Other	YES	NO

BLOOD DISORDERS

Anemia	YES	NO
Clotting Problems	YES	NO
Hemophilia	YES	NO
Other	YES	NO

ARTHRITIS

Rheumatoid	YES	NO
Osteoarthritis	YES	NO
Gout	YES	NO
Other	YES	NO

MISCELLANEOUS

Blood Clots	YES	NO
Thrombophlebitis	YES	NO
Sleep Apnea	YES	
Any other disease	YES	NO

List: _____

MENTAL HEALTH/PSYCHIATRIC

Depression	YES	NO
Anxiety	YES	NO
Bipolar Disorder	YES	NO
Eating Disorder	YES	NO
ADD/ADHD	YES	NO
Insomnia	YES	NO

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SURGICAL HISTORY

Please list all prior surgeries and year.

_____
_____
_____

HOSPITALIZATIONS

Have you ever been hospitalized for an illness, surgery, or childbirth? If yes, please list reason and provide dates.

_____
_____
_____

List Physicians seen in the last 5 years (most recent first)

_____
_____

Is there any chance that you could be pregnant (Circle one)? YES NO Not Sgure

Any history of abnormal menstrual cycle or PAP smear? YES NO If yes, explain_____

Age of first period _____ 1st day of last menstrual period _____

Taking estrogen? YES NO Menopause? YES NO If yes, year_____

FAMILY HISTORY

Heart problems	YES	NO	Who: _____	Stroke	YES	NO	Who: _____
Diabetes	YES	NO	Who: _____	Epilepsy	YES	NO	Who: _____
High Blood Pressure	YES	NO	Who: _____	Tuberculosis	YES	NO	Who: _____
High Cholesterol	YES	NO	Who: _____	Cancer	YES	NO	Who: _____
Obesity	YES	NO	Who: _____	Arthritis	YES	NO	Who: _____
Dementia	YES	NO	Who:_____	Obesity	YES	NO	Who:_____

Any other illnesses not listed above? If yes, please list illness and family member:

_____
_____
_____
_____
_____

MENTAL HEALTH/PSYCHIATRIC

Have you ever been diagnosed with a mental health/psychiatric disorder (anxiety, depression, bipolar, insomnia, ADHD, etc)? _____
If yes, please explain and provide dates.

_____
_____
_____

Have you ever been hospitalized for a mental illness/psychiatric illness? _____ If yes, please explain and provide dates.

_____
_____
_____

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Current Psychiatric Medications and Dose:

Previous Psychiatric Medications and Dose:

Family Psychiatric History (anxiety, depression, bipolar, ADHD, etc.)

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GIMBS, LLC

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial, and privacy policies. If you have any questions, please inform a member of our front-desk staff.

Consent for Medical Treatment

I authorize the health care providers of GIMBS, LLC and their health care team to render the evaluation and medical treatment necessary. I further authorize the use of x-rays, injections, or other diagnostic tests and treatment as determined necessary by my health care provider.
_____ Patient/Guardian Initials

Consent for Electronic Prescribing

I authorize the health care providers and other licensed providers of GIMBS and their healthcare team to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications from any and all health care providers.
_____ Patient/Guardian Initials

Consent for Student Participation

I understand that my health care provider and/or other GIMBS personnel may be accompanied and/or assisted by students in various fields of study related to healthcare, such as nursing, interns, and other allied health fields, and at various stages in their education. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my health care provider.
_____ Patient/Guardian Initials

No Show and Cancellation Policy

There is a $50 No Show fee applied to any visit that is not cancelled at 24 hours prior to appointment. We understand there are emergencies that arise that one is sometimes unable to control. We will take that into consideration when the appointment is cancelled. After 3 no show/cancelled appointments GIMBS reserves the right to no longer see you as patient.
____ Patient/Guardian Initials

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by GIMBS. I assign and authorize payments of medical insurance benefits to GIMBS directly, and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fees, court costs, and collection agency costs in the event default of payment of my charges. It is my responsibility to contact my insurance company and/or my employer to verify that GIMBS and its licensed medical providers are participants in my insurance plan prior to treatment at GIMBS. GIMBS does not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance products, and I am responsible for the full payment of services at the time rendered.

If my insurance plan requires a referral in order to be treated by a GIMBS provider, it is my responsibility to obtain the referral prior to being treated at GIMBS. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

GIMBS will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments, and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or with a plan GIMBS does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network," I am responsible for the balance.

Some insurance companies may determine that certain medical supplies and services that healthcare professionals prescribe for the patient's well-being are not covered. I agree to pay for these supplies and services in the event my insurance company denies coverage.

Signature of Patient/Guardian: _____ Date: _____

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Financial Policy

1. As a courtesy to our patients, we file both primary and secondary insurance claims. We a committed to help each patient obtain the maximum allowable benefit from the insurance company
2. Each patient is financially responsible for any amount not covered by their insurance policy. If applicable, including but not limited to, the amount of any copayment and/or deductible. Patients who are entitled to Medicare benefit are financially responsible for the amount of any applicable copayment/or deductible.
3. Payment in full of each patient's account balance must be made within 60 days of service even if the insurance carrier has not paid the claim by that time.
4. GIMBS accepts cash, check, bank debit card, MasterCard, Visa, American Express, and Discover. In the instance of a returned check you will be subject to a $50 processing fee and a check will longer be accepted.

I have read and understood the financial policy. I further understand that I am financially responsible for payment of services.

Patient/Guardian Signature_____ Date _____

Due to the high number of calls our office has received for medications and treatment between appointments and/or after hours, there will be a $35 fee assessed for all calls needing medical treatment between appointments Monday - Thursday. The fee for Friday- Sunday and holidays is $50. This is a convenience GIMBS provides to assist your needs when you are out of town or unable to come in for an appointment. We require a valid credit card to remain on file on your account for this service.

Patient Signature_____ Date _____

In the event we cannot contact you, please list family members or other persons, if any, whom we may inform about your general medical condition and diagnosis.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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Controlled Substance Agreement

I understand that this is Agreement is essential to trust and confidence necessary in a doctor/patient relationship that my doctor undertakes to treat me based on my compliance with this Agreement.
I understand that if I break this Agreement, my doctor will stop prescribing these controlled medications.
I understand if I violate this agreement my doctor, depending on the medication and violation, may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms or may recommend a drug-dependence treatment program.
I will communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping relieve the symptoms.
I will not use any illegal drugs, including marijuana, cocaine, methamphetamine, etc. Testing positive for any of these drugs will be grounds for immediate dismissal.
I will not share, sell, or trade my medication with anyone. I will not take other people's medication.
I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, dentist, or hospital. I will immediately notify GIMBS and provide office/hospital notes from any visit to other physicians or hospital along with list of medications prescribed. I will notify any other physician, dentist, or hospital that I am on a "*Controlled Substance Agreement*" with GIMBS prior to treatment.
I will safeguard my medicines from loss or theft. Lost or stolen medicines will *NOT* be replaced.
I agree that refills of my prescriptions for controlled substances will be made only at the time of an office visit during regular office hours. No refill will be available during evenings or weekends. GIMBS does not call in controlled medicines, so *DO NOT* ask.
I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including state Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy, and if so desired by my physician, obtain a prescription history from my pharmacist which will include all prescriptions filled by any and all physicians seen in the prior 24 months. I authorize any health clinics or doctors offices that I have received treatment in to release any and all of my personal health information including drug test and mental health records to GIMBS as requested by GIMBS. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my medication. These tests will be at my own expense.
I understand that I may be called for a pill count. If you are called for a pill count, you will have 24 hours to bring all of your medications to be counted. If you fail to make this mandatory pill count, you will be discharged from this agreement and will not receive any prescriptions for controlled substances from this office.
I agree that I will use my medicine as a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
I will bring all unused controlled substances to every office visit.
I agree that, if directed by my physician, I will undergo medically indicated conservative treatment aimed at reducing my symptoms thus reducing my need for medications. Failure to comply may result in dismissal from the program.
I agree to follow these guidelines that have been fully explained to me

Patient's Name: _____

Patient's Signature: _____

Date: _____

Physician's Signature: _____

Witnessed by: _____

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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data ("the transaction rules"); the keeping and use of patient records ("privacy rules"); and storage and access to health care records ("the security rules"). HIPPA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect the HIPPA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you now what patient protections HIPPA affords all of us. In primary care and mental health care, confidentiality and privacy are central to the success of a therapeutic relationship; and as such, you will find we will do all we can to protect the privacy of all medical and mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters

I understand and have been provided a copy of Getz Internal and Behavioral Services LLC's Patient Notification of Privacy Rights document which provides detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

_____ _____

Print Name Date

_____

Signature of Patient or Guardian

_____

Relationship to Patient of Person Signing Notification

_____

If Legal Charge, describe representative authority

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=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**
☐	☐	☐	☐

The Generalized Anxiety Disorder 7-Item Scale

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

Total Score: ☐ = **Add Columns** _____+_____+_____

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 at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**
_____	_____	_____	_____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

ADHD CHECKLIST Date_____ Client_____

Respondent _____ Relationship_____

Behaviors, Signs, and Symptoms	Before age 12 (circle)	Past 6 months (circle)
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	YES NO	YES NO
2. Often has difficulty sustaining attention in tasks or play activities.	YES NO	YES NO
3. Often does not seem to listen when spoken to directly.	YES NO	YES NO
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.	YES NO	YES NO
5. Often has difficulty organizing daily activities.	YES NO	YES NO
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental attention (e.g., schoolwork or homework).	YES NO	YES NO
7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, tools.)	YES NO	YES NO
8. Is often easily distracted by extraneous stimuli.	YES NO	YES NO
9. Is often forgetful in daily activities.	YES NO	YES NO
10. Often fidgets with hands or feet or squirms in seat.	YES NO	YES NO
11. Often leaves seat in classroom or in other situations in which remaining seated is expected.	YES NO	YES NO
12. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness.)	YES NO	YES NO
13. Often has difficulty playing or engaging in leisure activities quietly.	YES NO	YES NO
14. Is often "on the go" or often acts as if "driven by a motor."	YES NO	YES NO
15. Often talks excessively.	YES NO	YES NO
16. Often blurts out answers before questions have been completed.	YES NO	YES NO
17. Often has difficulty awaiting turn.	YES NO	YES NO
18. Often interrupts or intrudes on other (i.e., butts into conversations or games.)	YES NO	YES NO
Number of YES responses to Items 1 - 9:		
Number of YES responses to Items 10-18:		

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. 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.

Patient name: _____

Date of birth: _____

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	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four 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

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+