SHARP Rees-Stealy Medical Centers

# PATIENT INTAKE FORM

AFFIX PATIENT LABEL HERE

***INTERNAL USE ONLY*** ***BMI:**_____

BP:_____ T:_____ Ht:_____

P:_____ R:_____ Wt:_____

**At Sharp Rees-Stealy, it is important that your concerns are heard.**
**Please complete the information below to assist us with your visit today.**

**My major concern today is:**

**If time permits, other issues I would like to discuss are:**

| | YES | NO | |
|---|---|---|---|
| **Do we need to update your address or phone #?** | | | **New #/Address:** |
| **Do you need a note for work/school or any other form?** | | | |
| **Do you need medications refilled?** | | | **Name of medication(s):** |
| ***Do you use any tobacco products?** | | | **Type of tobacco:** |
| ***Have you recently received care such as inpatient hospitalization, ER visits, Urgent Care visits, nursing home stays, or visits with other physicians?** | | | **Which facility:** |
| **You can now get a summary of today's visit through our patient portal. If you aren't already signed up, would you like more information?** | | | |

***If you are 64 years of age or younger, STOP here.*** STOP

***If you are 65 years of age or older, please complete the two questions below:***

| ***Question #1: Fall Screening** | YES | NO |
|---|---|---|
| **1. Have you fallen in the last calendar year?** | | |
| **a. If yes, how many times? _____** | | |
| **b. Were you injured?** | | |

***Question #2: Depression Screening**

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

| | Not at all | Several days | More than half the day | 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** |

STOP

# INTERNAL USE ONLY

| | |
|---|---|
| **FOR OFFICE CODING ONLY**<br>**ADD QUESTIONS 1 & 2 FROM PAGE 1** | **_____ + _____ + _____ + _____**<br>**= TOTAL SCORE: _____** |

| | Not at all | Several days | More than half the day | Nearly every day |
|---|---|---|---|---|
| **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 ONLY**<br>**ADD QUESTIONS 1-9 FROM PAGES 1 & 2** | **_____ + _____ + _____ + _____**<br>**= TOTAL SCORE: _____** |

**INTERNAL USE ONLY**

**Pain Scale *(Provider use only)***: _____

**Depression Screening:** **Provider action needed?**

Depression on problem list? (YES/NO) If yes, skip question ..... YES NO
*(Document once a calendar year)*

**Fall Screening:**

Criteria 65+: If 2 or more falls or 1 fall with injury ..... YES NO
*(Document once a calendar year)*

**BMI Screening:**

18-64 years: If <18.5 or ≥25 provider action needed ..... YES NO
*(Document Wt & Ht every 6 months)*

65+ years: If <23 or ≥30 provider action needed ..... YES NO
*(Document Wt & Ht every 6 months)*

**Transitions of Care 65+:**

Patient outside SRS or doesn't share same E.H.R. ..... YES NO

**Social History:** Smoking status documented changed or unchanged *(Document once a calendar year)* ..... YES NO

Patient education material provided *(Document once a calendar year)* ..... MD CS