PATIENT REGISTRATION FORM

Patient Information			
Last Name:	**First Name:**	**Middle Name**:	
Date of Birth:	**Social Security Number:**		
If Minor, Guardian Name and Relation to Patient:			
Gender Identity: ☐ Choose not to disclose ☐ Male ☐ Female ☐ Transgender ○ Male-Female ○ Female-Male ☐ Non-Binary Preferred Pronouns: ☐ she, her, hers ☐ he, him, his ☐ they, them, theirs ☐ not listed **Preferred name** :_____ (*For billing purposes the name listed on your chart will be shown as your legal name, but office staff will make notation in your chart and make every attempt to address you by your preferred name)*			
Address: ☐ Homeless	**City:**	**State:**	**Zip Code:**
Mailing Address *if different*:			
Primary Phone: ☐ Home ☐ Cell ( )	**Alternate Phone:** ☐ Home ☐ Cell ( )		
E-Mail Address:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Other: _____			
Primary Language: **Interpreter Needed:** ☐ Yes ☐ No	**Religion:**		
Ethnicity:	**Race:** ☐ White ☐ Hispanic ☐ Native/American Indian ☐ Black-African American ☐ Asian-Pacific Islander ☐ Other:_____		
Emergency Contact			
Last Name, First Name:	**Relationship:**	**Phone Number:**	
Employment			
Employment Status ☐ Student: ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Employed: ☐ Full-time ☐ Part-time ☐ Unemployed			
Employer Name:	**Occupation:**		
Employer Address:	**Employer Phone:**		
Pharmacy Information			
Name:	**Address:**	**Phone Number:**	

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name: _____ DOB: _____

I give permission for Atiga Family Practice to provide my personal health information checked below

☐ Scheduling/Appointment information

☐ Medical information, including symptoms, diagnosis, medications, and treatment plan

☐ Health information, including symptoms, diagnosis, medications, and treatment plan regarding
(* items below must be checked, or this information cannot be given);
☐ Substance abuse ☐ Behavioral health ☐ Developmental disability ☐ HIV/AIDS

☐ Lab/Test results

☐ Billing and payment information

☐ All health information (* Protected health information items must be checked to give this information)

to the below named individuals/companies:

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.
Alternate date of expiration: _____

- I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Atiga Family Practice is permitted or required by law to release this information. For example, Atiga Family Practice may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Atiga Family Practice is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).
- I understand that this permission will remain in effect until the date stated above or until such time as I *revoke it in writing* (an updated agreement form will also revoke the validity of this specific agreement).

_____ _____
Patient/Authorized Representative Signature Date

If other than patient signing, state relationship: _____

☐ By checking this box, I agree that I am electronically signing this document.
☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically.

ANNUAL MINOR HEALTH HISTORY UPDATE

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Name of person completing form/
Nombre de la persona que completa el formulario: _____

Relationship to patient/Relación con el paciente:
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián

Home information/ Información de la casa:

Whom does the patient reside with? / ¿Con quién reside el paciente?
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián
How many people reside in the home/Cuantas personas residen en el hogar: _____
Parents are/ Los padres' son: ☐ Married/Casado ☐ Divorced/Divorciado ☐ Separated/Apartado ☐ Deceased/Fallecido
Is there drug, alcohol or smoking in the home?/¿Hay drogas, alcohol o fumar en casa? ☐ Yes/Sí ☐ No

Medical Diagnosis/Diagnóstico Médico

Have you been diagnosed with any new conditions since your last office visit?/ ¿Le han diagnosticado alguna afección nueva desde su última visita al consultorio? ☐ No

If yes, please list the date, diagnosis, and the provider or medical group who diagnosed you/
En caso afirmativo, indique la fecha, el diagnóstico y el proveedor o grupo médico que le diagnosticó:

Date of Diagnosis/ Fecha de diagnóstico	Diagnosis/Diagnóstico	Provider/Medical Group Name Nombre del proveedor/grupo médico

Surgeries/Cirugías

Have you had any surgeries since your last office visit? /¿Ha tenido alguna cirugía desde su última visita al consultorio? ☐ No

If yes, please list the date, surgery, and the name of the provider or medical group who performed it/
En caso afirmativo, indique la fecha, la cirugía y el nombre del proveedor o grupo médico que la realizó:

Date of Surgery/ Fecha de la cirugía	Surgery/Cirugía	Provider/Medical Group Name Nombre del proveedor/grupo médico

Hospitalizations/Hospitalizaciones

Have you been hospitalized (admitted as an inpatient) since your last office visit? ☐ No
¿Ha sido hospitalizado (admitido como paciente hospitalizado) en algún hospital desde su última visita al consultorio?

If yes, please list the dates you were admitted, the reason, and the name of the hospital/
En caso afirmativo, indique las fechas en que fue admitido, el motivo y el nombre del hospital:

ANNUAL MINOR HEALTH HISTORY UPDATE CONTINUED

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Dates of Stay / Fechas de estancia	Reason for Hospitalization/ Motivo de la hospitalización	Name of Hospital/ Nombre del Hospital

Vaccinations/ Vacunas:

☐ **No previous vaccinations/ Sin vacunas previas**

****PLEASE PROVIDE OFFICE WITH COPY OF PREVIOUS VACCINATION****

**** POR FAVOR PROPORCIONE A LA OFICINA UNA COPIA DE LAS VACUNAS ANTERIORES ****

and TB test documents/y documentos de prueba de tuberculosis

Screenings/Proyecciones

Date last completed/Fecha de finalización por última vez

Eye exam/Examen de la vista: _____ Hearing Screen/Pantalla de audición: _____

☐ No previous eye exam/Sin examen ocular previo ☐ No previus hearing exam/ Sin examen auditivo previo

Family History/ Historia familiar

Have any family members been diagnosed with the below since your last office visit? / ☐ None, /Nada

¿Algún miembro de la familia ha sido diagnosticado con lo siguiente desde su última visita al consultorio?

If yes, please list which family member /*En caso afirmativo,* indique qué miembro de la familia

Diabetes	
High Blood Pressure/Presión arterial alta	
Heart Disease/ Cardiopatía	
Stroke/ Carrera	
Mental Illness/ Enfermedad mental	
Cancer (Also list type/También tipo de lista)	

Do you have any new concerns you would like to discuss with your provider today? ☐ No

Signature/Firma _____

☐ By checking this box, I agree that I am electronically signing this document. / Al marcar esta casilla, acepto que estoy firmando electrónicamente este documento.

☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically./ Al marcar esta casilla, acepto que he revisado este documento, pero prefiero firmarlo manualmente en lugar de hacerlo electrónicamente.

Provider Signature/Firma del proveedor _____

ADDITIONAL HEALTH HISTORY FOR WOMEN

For Female Patients Only/ Solo para pacientes femeninas:

Name/Nombre:	**Age/Edad:**	**DOB/Fecha de nacimiento:** / /	**Today's Date/Fecha:**

Menstrual History/ Historia menstrual: ☐ Period has not yet started/ El período aún no ha comenzado

Age when period started? / ¿ Edad cuando comenzó el período _____

How many days does your cycle last? / ¿Cuántos días dura tu ciclo _____

How many days between your cycle? / ¿Cuántos días entre su ciclo? _____

Is this the same each month? / ¿Es lo mismo todos los meses? ☐ Yes/ Sí ☐ No

Flow/ Flujo: ☐ Light/ Ligera ☐ Moderate/ Moderada ☐ Heavy/ Pesada

Do you use/ Lo usas: ☐ Panty Liner/ Delineador de bragas ☐ Thin Pad/ Almohadilla fina

☐ Maxi Pad/ Toalla sanitaria ☐ Tampon absorbency/ absorbencia _____

☐ Other (specify)/ Otra (especificar): _____

How often do you need to change the above? / ¿Con qué frecuencia necesita cambiar lo anterior?

Every/ Cada _____ hours/horas.

Pain with period/ Dolor con el período: ☐ None/Ninguna ☐ Mild/Templada ☐ Moderate/Moderada ☐ Severe/Grave

Describe your symptoms/ Describe tus síntomas: _____

_____

***Menopause/ Menopausia*:**

Age when menopause started? / ¿ Edad de inicio de la menopausia _____

Exams/ Exámenes

Date of Last Pap Smear? / ¿Fecha de la última prueba de Papanicolaou _____

History of abnormal pap smears? / ¿Historial de pruebas de Papanicolaou anormales? ☐ Yes/ Sí ☐ No

If yes, what was the abnormality? / Si es así, ¿cuál fue la anomalía? _____

Date of last mammogram? / ¿Fecha de la última mamografía? _____

History of abnormal mammogram? / ¿Historial de mamografía anormal? ☐ Yes / Sí ☐ No

If yes, what was the abnormality? / En caso afirmativo, ¿cuál fue la anomalía? _____

Are you having any problems with your breast(s)?/ ¿Tiene algún problema con sus senos? ☐ Yes/ Sí ☐ No

Pregnancy History/ Historial de embarazo: ☐ Never/Nunca ☐ Currently/Actualmente

How far along are you? / ¿Qué tan lejos? _____

Number of/Número de:

pregnancies/embarazos (G) _____ Live births/Nacimientos en vivo _____ Miscarriages/Aborto espontáneos ____

Abortions/Abortos _____ Multiple birth deliveries/Partos múltiples _____ Living children/Niñas viviendo ____

Preterm deliveries (before 37 weeks)/Partos prematuros (antes de las 37 semanas _____

Full term deliveries/Entregas a plazo completo _____

Any complications during pregnancy or delivery? _____

_____

Patient Signature/ Firma del paciente _____

☐ By checking this box, I agree that I am electronically signing this document.

☐ By checking this box, I agree that I have reviewed this document, but prefer to sign the document manually vs electronically.

Provider Signature/ Firma del proveedor _____

ATIGA FAMILY PRACTICE

PATIENT NAME/ **DOB/** **TODAY'S DATE/**

Nombre del paciente: _____ **Fecha de nacimiento: _____** **Fecha: _____**

MEDICATIONS/MEDICAMENTOS

◯ No medications, vitamins or supplements taken/ No se toman medicamentos, vitaminas o suplementos

Please list ALL medicine you take including over the counter and supplements/
Por favor, enumere TODOS los medicamentos que toma incluyendo sobre el mostrador y suplmentos

Name/ el nombre	Dose/ la dosis	How often/ con que frecuencia	Taking for/ Tomar para	Prescriber/ Prescriptor

ALLERGIES TO MEDICATION/ALERGIAS A LA MEDICACIÓN

◯ No known allergies to medication/ No se conocen alergias a los medicamentos

Name of Medicine/ Nombre de la Medicina	Type of Reaction/ tip de reaccion

DURABLE MEDICAL EQUIPMENT/EQUIPO MÉDICO DURADERO

List any medical equipment you use at home? (Ex: CPAP, glucometer etc.)/
Enuniere cualguier equipo medico que use en casa (por ejemplo: CPAP, glucómetro, etc.)

◯ No Medical Equipment/Sin equipo médico

Periodic TB Risk Assessment

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

TB SYMPTOM REVIEW:

Do you currently have any of the following symptoms?	YES	NO
1. Cough that has lasted more than 3 weeks?	○	○
2. Coughing up blood?	○	○
3. Unexplained weight loss?	○	○
4. Chronic Fever?	○	○
5. Drenching night sweats?	○	○

(IMMEDIATE CXR AND MEDICAL EVALUATION IS NEEDED IF THE ANSWER IS YES TO ANY OF THE ABOVE)

NEW TB MEDICAL RISKS FOR TB DISEASE PROGRESSION:

Since your last office visit do you have a NEW diagnosis of:	YES	NO
1. HIV?	○	○
2. Diabetes?	○	○
3. Cancer?	○	○
4. Kidney Failure?	○	○

OR have you started taking any of the following IMMUNOSUPPRESSIVE MEDICATIONS:

1. Prednisone?	○	○
2. Methotrexate?	○	○
3. Cyclosporine?	○	○
4. Chemotherapy?	○	○
5. IV rheumatoid, psoriatic arthritis or Chron's disease medications?	○	○

NEW TB EXPOSURE RISK:	YES	NO
In the past 2 years …		
1. Have you had contact with anyone with known TB disease?	○	○
2. Have you spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe?	○	○
3. Have you been in incarcerated in either prison or jail?	○	○
4. Have you been homeless or living in a single room occupancy hotel?	○	○
5. Have you injected street drugs?	○	○
6. Have you worked with homeless persons, migrant workers or drug users?	○	○
7. Have you worked as a health care worker?	○	○

New or repeat TB test (Mantoux or blood test) is needed if the answer is YES to ANY of the above questions

REQUIRED: Document the patients Mantoux or blood test results in the medical record and database.

Provider Signature:_____

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

			Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?		Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?		
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?		
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?		
5	Do you exercise or play sports most days of the week?		Physical Activity
6	Are you concerned about your weight?		
7	Do you watch TV or play video games less than 2 hours per day?		
8	Does your home have a working smoke detector?		Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?		
10	Do you always wear a seatbelt when riding in a car?		
11	Do you spend time in a home where a gun is kept?		
12	Do you spend time with anyone who carries a gun, knife, or other weapon?		
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?		
14	Have you ever witnessed abuse or violence?		
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?		
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?		
17	Do you brush and floss your teeth daily?		Dental Health
18	Do you often feel sad, down, or hopeless?		Mental Health
19	Do you spend time with anyone who smokes?		Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?		
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?		

NAME: _____ **DOB:** ____/____/____

22	Do you use medicines not prescribed for you?		
23	Do you drink alcohol once a week or more?		
24	If you drink alcohol, do you drink enough to get drunk or pass out?		
25	Do you have friends or family members who have a problem with drugs or alcohol?		
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?		
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.		
27	Have you ever been forced or pressured to have sex?		Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*		
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?		
30	Have you or your partner(s) had sex with other people in the past year?		
31	Have you or your partner(s) had sex without using birth control in the past year?		
32	The last time you had sex, did you use birth control?		
33	Have you or your partner(s) had sex without a condom in the past year?		
34	Did you or your partner use a condom the last time you had sex?		
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?		
36	Do you have any other questions or concerns about your health?		Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Pediatric ACEs and Related Life Events Screener (PEARLS)

TEEN (Parent/Caregiver Report) - To be completed by: Caregiver

Patient Name: _____ _____ DOB: ____/____/____

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Has your child ever lived with a parent/caregiver who went to jail/prison?	☐
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	☐
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	☐
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	☐
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	☐
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	☐
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

This tool was created in partnership with UCSF School of Medicine.

Patient Name: _____ DOB: ____/____/____

PART 2:	Please check "Yes" where apply. √
1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2. Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3. Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	☐
5. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	☐
6. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
7. Has your child ever lived with a parent or caregiver who died?	☐
8. Has your child ever been detained, arrested or incarcerated?	☐
9. Has your child ever experienced verbal or physical abuse or threats from a romantic partners? *(for example, a boyfriend or girlfriend)*	☐

How many "Yes" did you answer in Part 2?: ☐

Today's Date: _____

Name of person completing form and relation to patient:

_____

Provider Signature: _____

Pediatric ACEs and Related Life Events Screener (PEARLS)

TEEN (Self-Report)- **To be completed by: Patient**

NAME: _____ **DOB:** ____/____/____

At any point in time since you were born, have you seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Have you ever lived with a parent/caregiver who went to jail/prison?	☐
2. Have you ever felt unsupported, unloved and/or unprotected?	☐
3. Have you ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put you down?	☐
5. Has your biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Have you ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not being cared for when sick or injured even when the resources were available)*	☐
7. Have you ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or have you ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at you? Or has any adult in the household ever hit you so hard that you had marks or were injured? Or has any adult in the household ever threatened you or acted in a way that made you afraid that you might be hurt?	☐
9. Have you ever experienced sexual abuse? *(for example, has anyone touched you or asked you to touch that person in a way that was unwanted, or made you feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with you)*	☐
10. Have there ever been significant changes in the relationship status of your caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

This tool was created in partnership with UCSF School of Medicine.

Name: _____ **DOB:** _____/_____/_____

Part 2: Please check all that apply

1. Have you ever seen, heard, or been a victim of violence in your neighborhood, community or school? ☐
   (for example, targeted bullying, assault or other violent actions, war or terrorism)
2. Have you experienced discrimination? ☐
   (for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)
3. Have you ever had problems with housing? ☐
   (for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)
4. Have you ever worried that you did not have enough food to eat or that food would run out before you or your parent/caregiver could buy more? ☐
5. Have you ever been separated from your parent or caregiver due to foster care, or immigration? ☐
6. Have you ever lived with a parent/caregiver who had a serious physical illness or disability? ☐
7. Have you ever lived with a parent or caregiver who died? ☐
8. Have you ever been detained, arrested or incarcerated? ☐
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners? ☐
   (for example, a boyfriend or girlfriend)

How many "Yes" did you answer in Part 2?: ☐

Today's Date: _____

Provider Signature: _____

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: / / Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	◯	◯	◯	◯
B	Feeling down, depressed, or hopeless	◯	◯	◯	◯
C	Trouble falling or staying asleep, sleeping too much	◯	◯	◯	◯
D	Feeling tired or having little energy	◯	◯	◯	◯
E	Poor appetite or overeating	◯	◯	◯	◯
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
G	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
H	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	◯	◯	◯	◯
I	Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	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 ☐

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯
Worrying too much about different things	◯	◯	◯	◯
Trouble relaxing	◯	◯	◯	◯
Being so restless that it's hard to sit still	◯	◯	◯	◯
Becoming easily annoyed or irritable	◯	◯	◯	◯
Feeling afraid as if something awful might happen	◯	◯	◯	◯
Total Score (add your column scores)				
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 ☐

Providers signature: _____

Date: _____