

ATIGA FAMILY PRACTICE

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:
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**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/Cuántas 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:
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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 previous 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 _____

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? | <input type="radio"/> | <input type="radio"/> |
| 2. Coughing up blood? | <input type="radio"/> | <input type="radio"/> |
| 3. Unexplained weight loss? | <input type="radio"/> | <input type="radio"/> |
| 4. Chronic Fever? | <input type="radio"/> | <input type="radio"/> |
| 5. Drenching night sweats? | <input type="radio"/> | <input type="radio"/> |

(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? | <input type="radio"/> | <input type="radio"/> |
| 2. Diabetes? | <input type="radio"/> | <input type="radio"/> |
| 3. Cancer? | <input type="radio"/> | <input type="radio"/> |
| 4. Kidney Failure? | <input type="radio"/> | <input type="radio"/> |

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

- | | | |
|---|-----------------------|-----------------------|
| 1. Prednisone? | <input type="radio"/> | <input type="radio"/> |
| 2. Methotrexate? | <input type="radio"/> | <input type="radio"/> |
| 3. Cyclosporine? | <input type="radio"/> | <input type="radio"/> |
| 4. Chemotherapy? | <input type="radio"/> | <input type="radio"/> |
| 5. IV rheumatoid, psoriatic arthritis or Chron's disease medications? | <input type="radio"/> | <input type="radio"/> |

NEW TB EXPOSURE RISK:

- | In the past 2 years ... | YES | NO |
|---|-----------------------|-----------------------|
| 1. Have you had contact with anyone with known TB disease? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe? | <input type="radio"/> | <input type="radio"/> |
| 3. Have you been incarcerated in either prison or jail? | <input type="radio"/> | <input type="radio"/> |
| 4. Have you been homeless or living in a single room occupancy hotel? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you injected street drugs? | <input type="radio"/> | <input type="radio"/> |
| 6. Have you worked with homeless persons, migrant workers or drug users? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you worked as a health care worker? | <input type="radio"/> | <input type="radio"/> |

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

9 – 11 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	Grade in School:
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
Nutrition

1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?			
2	Does your child eat fruits and vegetables at least two times per day?			
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?			
4	Does your child drink more than one cup (8 oz.) of juice per day?			
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?			
6	Does your child exercise or play sports most days of the week?			
7	Are you concerned about your child's weight?			
8	Does your child watch TV or play video games less than 2 hours per day?			
9	Does your home have a working smoke detector?			
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?			
11	Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?			
12	Does your child spend time near a swimming pool, river, or lake?			
13	Does your child spend time in a home where a gun is kept?			
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?			
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?			

Physical Activity

Safety

Name: _____ DOB: _____

16	Has your child ever witnessed or been a victim of abuse or violence?				
17	Has your child been hit or has your child hit someone in the past year?				
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?				
19	Does your child brush and floss her/his teeth daily?				Dental Health
20	Does your child often seem sad or depressed?				Mental Health
21	Does your child spend time with anyone who smokes?				Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?				
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?				
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?				
25	Does your child have friends or family members who have a problem with drugs or alcohol?				
26	Has your child started dating or “going out” with boyfriends or girlfriends?				Sexual Issues
27	Do you think your child might be sexually active?				
28	Do you have any other questions or concerns about your child’s health or behavior?				Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> 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:

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - 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)

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



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

Page 1 of 2

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 lived with a parent/caregiver who had a serious physical illness or disability?

6. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?

7. Has your child ever lived with a parent or caregiver who died?

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

Today's Date: _____

Name of person completing form and relation to patient:

Provider Signature: _____

