# B-Healthy Clinic
# Patient Information Form

## PERSONAL INFORMATION

**Patient Name:** _____

**Birth date:** ____/____/____ **Social Security**_____ **Male**_____ **Female**_____

**Address**_____ **Apt#:**_____ **City:** _____ **State:** _____ **Zip:** _____

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

**Email Address :**_____**( Gmail Preferred)**

**Marital status: Married:** _____ **Single:** _____ **Divorced:** _____ **Widowed:** _____ **Other:** _____

## INSURANCE INFORMATION

**Name of employer:** _____ **Occupation:** _____
**Primary Insurance:** _____ **Policy Holder:** _____
**Responsible Party:** _____ **Relationship to patient:** _____
**Social Security:** _____ **Birth date:** ___/___/___ **Effective Date:** _____
**Policy Number:** _____ **Group Number:** _____

## DO YOU HAVE ADDITIONAL INSURANCE?

**YES**_____**NO**_____
**(If yes please fill out the following section)**
**Secondary insurance name:** _____ **Policy Holder:** _____

**Social Security:** _____ **Birth date:** ___/___/___ **Effective date:** _____

**Policy Number:** _____ **Group Number:** _____

**Pharmacy:**_____

## PERSON TO NOTIFY IN CASE OF EMERGENCY:

**Name:** _____ **Telephone Number:** _____

I consent to treatment necessary for the care of the aforementioned patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company; I allow fax transmittal of my records, if necessary. I acknowledge full financial responsibility for services rendered by B-Healthy Clinic. I understand that payment and charges incurred responsible attorney fees and collection costs in the event of default of payment charges. I further authorize and request that insurance payments be made directly to B-Healthy Clinic. I have read and fully understand the above consent from, treatment, financial, responsibility, release of medical information and insurance authorization.

**Signature**_____ **Date** _____

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ 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 _____



A2663B 10-04-2005

# HEALTH HISTORY

Patient Name_____ Birth Date____/____/____ Patient #_____

To help us meet all your healthcare needs/ please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date_____
Place of birth_____
Highest level of school _____
Occupation _____
Previous occupation_____
Marital Status_____
Hobbies_____
Exercise/ recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit_____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last Dental exam_____
Please list all allergies (foods, drugs, and environment)
_____
_____
_____

When was your last Physical exam? _____
Name of doctor_____ Phone _____
please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none ☐
_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs): none ☐
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred: none ☐
_____
_____
_____

**Chief Complaints**
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____
_____

**Past medical history**
Have you ever had the following? (Circle "no" or "yes". Leave blank if uncertain)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Measles | no | yes | Migraine headaches | no | yes | Hives or Eczema | no | yes |
| Mumps | no | yes | Tuberculosis | no | yes | AIDS or HIV+ | no | yes |
| Chickenpox | no | yes | Diabetes | no | yes | Infection Mono | no | yes |
| Whooping cough | no | yes | Cancer | no | yes | Bronchitis | no | yes |
| Scarlet fever | no | yes | Polio | no | yes | Mitral Value Prolapse | no | yes |
| Diphtheria | no | yes | Glaucoma | no | yes | Stroke | no | yes |
| Smallpox | no | yes | Hernia | no | yes | Hepatitis | no | yes |
| Pneumonia | no | yes | Blood or Plasma | | | Ulcer | no | yes |
| Rheumatic fever | no | yes | transfusions | no | yes | Kidney Disease | no | yes |
| Heart Disease | no | yes | Back trouble | no | yes | Thyroid disease | no | yes |
| Arthritis | no | yes | High or low blood | | | Bleeding tendency | no | yes |
| Venereal Disease | no | yes | pressure | no | yes | Any other disease | no | yes |
| Anemia | no | yes | Hemorrhoids | no | yes | (please list) _____ | | |
| Bladder infections | no | yes | Date of last chest x-ray _____ | | | _____ | | |
| Epilepsy | no | yes | Asthma | no | yes | _____ | | |

**Family history**
Has any blood relative had any of the following (Circle "no" or "yes". Leave blank if uncertain.)

| | | | **Relationship** | | | | **Relationship** |
|---|---|---|---|---|---|---|---|
| Cancer | no | yes | _____ | Stroke | no | yes | _____ |
| Tuberculosis | no | yes | _____ | Epilepsia | | no yes | _____ |
| Diabetes | no | yes | _____ | Allergies | no | yes | _____ |
| Heart disease | no | yes | _____ | Anemia | no | yes | _____ |
| High blood pressure | no | yes | _____ | Bleeding tendency | no | yes | _____ |

**Family history (cont.)**
(Circle "no" or "yes". Leave blank if uncertain)

Present age, _____ if living, health (good, fair, poor) _____
or age of death_____ if deceased, cause of death _____

| | | **Relationship** |
|---|---|---|
| Asthma | no | yes_____ |
| Chronic long Disease | no | yes_____ |
| Drug or alcohol problem | no | yes_____ |
| Mental illness | no | yes_____ |
| Leukemia | no | yes_____ |
| Migraine headaches | no | yes_____ |
| Obesity | no | yes_____ |
| Thyroid Disease | no | yes_____ |
| Ulcer | no | yes_____ |
| Depression | no | yes_____ |
| High Cholesterol | no | yes_____ |
| Kidney Disease | no | yes_____ |
| Glaucoma | no | yes_____ |
| Gout | no | yes_____ |

Father _____
Mother_____
Siblings_____
_____
_____
_____

Spouse_____
_____
Children_____
_____

**Do you have now or have you had within the past year:**
(Circle "no" or "yes", leave Blank if uncertain.)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Weakness or paralysis | no | yes | Bloody sputum | no | yes | Joint pain or stiffness | no | yes |
| Tire easily or weakness | no | yes | Wheezing | no | yes | Swollen Joints | no | yes |
| Recent weight changes | no | yes | Chest pain or discomfort | no | yes | Muscle cramps or spasms | no | yes |
| Change in appetite | no | yes | Purple fingers or lips | no | yes | Sleeplessness | no | yes |
| Sensitivity to cold or heat | no | yes | Swelling of hands feet or ankles | no | yes | Seizures | no | yes |
| Persistent fever | no | yes | Difficulty breathing | no | yes | Depression | no | yes |
| Night sweats or hot flashes | no | yes | Heart Palpitations | no | yes | Memory loss | no | yes |
| Skin Rash | no | yes | Leg cramps walking and/or rest | no | yes | Poor coordination | no | yes |
| Skin trouble or changes | no | yes | Enlarged veins | no | yes | Dizziness or fainting spells | no | yes |
| Change in nails or hair | no | yes | Difficulty swallowing | no | yes | **Men only:** | | |
| Headaches | no | yes | Heartburn | no | yes | Discharge from penis | no | yes |
| Easy bleeding or bruising | no | yes | Frequent Belching | no | yes | Pain or lump in testicles | no | yes |
| Double vision | no | yes | Abdominal cramping | no | yes | impotence | no | yes |
| Blurred vision | no | yes | Nausea | no | yes | **Women only:** | | |
| Eye pain | no | yes | Vomiting | no | yes | Age period began_____ | | |
| Infected eye | no | yes | Vomiting or coughed up blood | no | yes | How many days do periods last? _____ | | |
| Do you wear glasses or contacts | no | yes | Chronic Diarrhea | no | yes | How days between periods? _____ | | |
| When was your last eye exam_____ | | | Chronic constipation | no | yes | Is the flow heavy | no | yes |
| Ringing in ears | no | yes | Rectal bleeding | no | yes | Do you bleed or spot | | |
| Discharge from ears | no | yes | Black tarry stools | no | yes | between periods | no | yes |
| Ear pain | no | yes | Dark urine | no | yes | Do you have pain or cramps | no | yes |
| Decrease in hearing | no | yes | Yellow jaundice | no | yes | Date if last period? _____ | | |
| Frequent nosebleeds | no | yes | Frequent Urination (day) | no | yes | Date of last pelvic exam? _____ | | |
| Frequent clods | no | yes | Frequent Urination (night) | no | yes | Date of last mammogram? _____ | | |
| Sinus trouble | no | yes | increase in thirst | no | yes | Any itching in vaginal area?_____ | | |
| Loss of smell | no | yes | Painful urination | no | yes | Pain with intercourse? | no | yes |
| Persistent Hoarseness | no | yes | Leakage of urination | no | yes | type of birth control used? _____ | | |
| Sore throat | no | yes | Difficulty in starting urine | no | yes | Number of pregnancies? _____ | | |
| Sore tongue or gums | no | yes | Blood in urine | no | yes | Number of full term births? _____ | | |
| Lump or discharge from breast | no | yes | Lack of sex drive | no | yes | Number of preterm term births? _____ | | |
| Chronic or frequent cough | no | yes | Hemorrhoids | no | yes | | | |
| Shortness of breath | no | yes | Backaches | no | yes | | | |

**x** _____ _____

**Signature of patient or parent if minor** **Date**

# HEALTH HISTORY

# B-Healthy Clinic

## NOTICE OF PRIVACY PRACTICES

**To our patients:**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations Created as a result of the Health Insurance portability and Accountability Act of 1996 (HIPPA)

**Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information certain special circumstances**

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect

information.

Lawsuits and similar proceedings in response to a court or administrator order. If required to do so by a law enforcement official. When necessary to reduce or prevent a serious threat to your health and safety or the health Safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forced (including veterans) and if required by the

appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To Correctional institutions or law enforcement officials if you are an inmate or under the

custody of law enforcement official.

8. For Worker's Compensation and similar programs.

**Your rights regarding your health information**

1. Communications. You can request that our practice communicate with you about your health

related issues in a particular manner or at a certain location. For instance, you may ask that we Contact you at home, rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in our use of disclosure of your health information for treatment,

payment, or health care options. Additionally, you have the right to request that we restrict our

disclosure of your health care information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. 3. You have the right to inspect and obtain a copy of the health information that may be used to

make decisions about you, including patient medical records and billing records but not including patient medical records and billing records, but not including psychotherapy notes.

You must submit your request in writing to:

B-Healthy Medical B-Healthy Medical 915OW. Indian School #105 4502 W. Indian School # A3

Phoenix AZ85037 Phoenix AZ 85031

(623)247-2300 (623)247-0414

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as the long as the information is kept by or for our practice. To request an amendment, you request must be written and submitted to B-Healthy Medical. You must provide with reason that supports your request for amendment.

5. You have a right to a copy of this notice. You are entitled to receive a copy of this Notice of

Privacy Practice. You may ask us to give you a copy of this notice at any time. To obtain a copy of the notice contact our front desk.

6. You have a right to file a complaint. If you believe you privacy rights have been violated, you

may file a complaint with our practice, or with the secretary of the Department of Health and Human Services. To file a complaint with our practice contact B-Healthy Medical as above for handling complaints. All complaints must be submitted in writing you will not be penalized for filling a complaint.

7. Right to provide an authorization for uses and disclosures that are not identified by this notice

or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please Contact B-Healthy Medical as above information provided for further information.

herby acknowledge that I have been presented with a copy of B-Healthy Medical Notice of Privacy Practices.

Signature: _____Date:_____

Printed Name:_____

# B-HEALTHY CLINIC

**Who should we contact in case of an emergency?**

**A quien podemos contactar en caso de una emergencia?**

**1)** Name/Nombre_____ Relationship/Parentesco _____

Address/Domicillo_____

City/Cuindad_____ State/Estado_____ Zip/CodigoPostal_____

Phone number/Numero telefonico _____-_____-_____

**2A) Do you have and Advance Directive for your health care?**
**(Living will or a Medical Power of Attorney)**

**Tiene usted Avance Directivo para su cuidado medio?**
**(Directiva Avanzada o Poder Legal Medico)**

Yes/SI_____ No/No_____ Initials/Iniciales _____

**2B) If you answered "Yes" Please provide a copy for your medical record. Thank You.**
**Si su respondio "Si" Porfavor de proveer de una copia para su rejistro medico. Gracias.**

**2C) If you answered ''no'' would you like information regarding an advanced directive?**
**Si su respondió 'no''le gustaría recibir información sobre una directiva avanzada?**

Yes/SI_____ No/No_____ Initials/Iniciales _____

Signature/Firma_____ Date/Fecha_____

---

FOR OFFICE USE ONLY/ SOLAMENTE PAR USO DE OFICINA

PATIENT GIVEN ADVANCED DIRECTIVE INFORMATION YES___/NO___

Received Date_____

Staff Members Initials_____

# CEB CAPITAL LLC DBA

## B-HEALTHY CLINIC

9150 W Indian School RD #111B
Phoenix, AZ 85037
Ph: 623-247-2300 Fax: 623-201-8276

AUTHORIZATION TO RELEASE MEDICAL RECORDS

*Patient Name/ Nombre de Patiente _____*
*SS#/Seguridad Social _____ Date of Birth/ Fecha de Nacimiento_____*
*Address/ Domicilio _____*
*City/ Ciudad _____ State/ Estado _____ Zip/ Codigo Postal _____*
*Phone Number/ Numero telefonico ( ) _____-_____*

*I hereby authorize/ Yo aqui authorizo:*

*Name/ Nombre _____*
*Address/ Domicilio _____*
*City/ Ciudad _____ State/ Estado _____ Zip/ Codigo Postal _____*
*Phone Number/ Numero telefonico ( ) _____-_____ Fax ( ) _____-_____*

*To release medical records information concerning the above named patient to:*
*Para divulgar información relativa a los registros médicos del paciente antes mencionado a:*

**CEB CAPITAL LLC DBA**
B-HEALTHY CLINIC
*9150 W Indian School Rd #111B*
*Phoenix, AZ 85037*
*Ph: 623-247-2300 F: 623-247-1010*
**please email bhealthyclinic@hotmail.com or place on disc**

*FOR THE PURPOSE OF:/ PARA EL PROPICITO DE:*

*___Appointment/ Cita*
*___Permanent Transfer/ Transferencia Permanente*

*MEDICAL RECORDS:/ REGISTROS MEDICOS*

*___Copy of all medical records of treatment received. / Copia de todos los expedientes médicos de tratamiento recibido.*
*___Copy of medical records covering dates from _____ to _____*
*Copia de los expedientes médicos que cubren las fechas de _____ a _____*
*___Other/ Otro _____*

*I hereby release B-Healthy Medical from any and all responsibility for fulfilling the authorization request for release of medical information. I have given my consent freely, voluntarily, and without coercion.*

*Por el presente comunicado de B-Healthy Mediacal de cualquier y toda responsabilidad por el cumplimiento de la solicitud de autorización para la divulgación de información médica . He dado mi consentimiento libre, voluntaria y sin coacción.*

_____ _____
*Patient Signature/ Firma del patiente* *Date/ Fecha*

*Parent/ guardian/POA/ Padre/ guardian/POA* *Date/ Fecha*

_____ _____