

***Lorraine Bonaldi, MSN, MBA, APRN, FNP-BC***

**Adult Assessment Initial Visit**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BD: \_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_Dr. \_\_\_\_\_Mr. \_\_\_\_\_Mrs. \_\_\_\_\_Ms. \_\_\_\_\_Prof \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaint ~ REASON FOR YOUR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENDER: male Pronouns: \_\_\_\_\_\_he/his \_\_\_\_\_she/her \_\_\_\_\_they/them**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best Phone to call\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OK To leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_\_Able to receive text messages? Yes \_\_\_\_No \_\_\_\_\_\_**

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Please provide copy)**

**Cash Pay: (Zelle)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP Status: \_\_\_\_Never Married \_\_\_\_\_Married \_\_\_\_Living with Partner \_\_\_\_Divorced**

**\_\_\_\_ Separated \_\_\_\_Widow/Widower \_\_\_\_\_ Other \_\_\_\_ Live Alone \_\_\_\_\_\_\_\_\_\_\_TYPE of housing**

**Spouse/Partner (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you safe? \_\_\_\_\_Yes \_\_\_\_ Unsure\_\_\_\_\_ Want to talk more privately? \_\_\_\_\_yes \_\_\_\_\_\_no**

**RACIAL/ETHNIC Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Language Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAITH Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Military: \_\_\_\_\_\_ Yes \_\_\_\_\_No \_\_\_\_\_ Active**

New or Established Patient

 Detailed history

 Detailed examination

 Medical decision making, moderate complexity

**How did you hear about Caring Hearts & Minds? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Interested in Hormone Replacement Therapy (HRT) via pellets: \_\_\_\_Yes No \_\_\_\_\_Unsure (tell me more about this)**

**Medication Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**

**­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Other meds/over the counter meds:**

**Sertraline**

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**Medical Information/Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries/Surgery History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have children? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No \_\_\_\_\_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have pets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you are over age 50, have you had a colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Females only: When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **When was your last PAP smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vaccinations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you interested in discussing vaccinations? \_\_\_ Yes \_\_\_\_ No TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_ COVID \_\_\_\_ Hepatitis \_\_\_\_TB \_\_\_\_HIV\_\_\_\_ STDs\_\_\_\_\_\_**

**Are you in pain today? \_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_ 0/10 scale \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health/Psychiatric History: depression and anxiety**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of emergency for your safety or the safety of others, whom may I call (Contact must be over age 18)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is allowed to have access to your medical records? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PFSH: (Past Family/Social History): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pertinent medical history of family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**WOMEN: post-partum anxiety or depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drug/Alcohol/Caffeine Use: \_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_What How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Quantity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Longest period of sobriety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any hospital Rehab? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nightmares? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Depression?** How long? More sad than happy? What makes it better?

 Depressed mood for > 2 weeks

 Sleep Loss of interest dec energy concentration guilt/worthlessness appetite change self-esteem

 psychomotor slowing irritability (ADHD)

**Anxiety** how often? How long? Triggers

 Excess worry restless easily fatigued irritability muscle tension dec sleep dec concentration

**Panic Attacks**

 Palpitations Sweating Trembling SOB/chest pain Nausea Dizziness Paralysis fear dying fear of

 “Going crazy”

**OCD: \_\_\_\_\_\_\_\_\_\_** what makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PTSD**  nightmares experience dreams/flashback avoidance behavior inc vigilance

**Past Psych Hx (**dx/hospitalizations/meds/violence) SA/cutting\_\_\_\_\_\_ SI\_\_\_\_\_\_ HI\_\_\_\_\_\_\_\_\_

Suicidal Ideations:

Plan: No

Intent/A No

Means: Notes: N/A

Homicidal Ideations:

Plan: No

Intent: No

Means: No

Notes: No

Aggressive Ideations:

Plan: No

Intent: No

Means: No

Obsessions: denies

Other: denies paranoia; a/v hallucinations

**Family Psych Hx:** Drugs Mental illness \_\_\_\_\_\_\_\_\_\_ SA/SI \_\_\_\_\_\_\_\_\_\_\_ Injury to self \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRRIBE any of the above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Review of Symptoms (as reported by pt.)**

\_\_\_\_ Neuro \_\_\_\_TBI \_\_\_\_SEIZ \_\_\_\_Stroke \_\_\_\_ Kidney \_\_\_\_Liver \_\_\_\_GI \_\_\_\_MSK\_\_\_\_\_SKIN \_\_\_\_Other

EYE doctor? \_\_\_\_\_ GYN/OB \_\_\_\_\_ Neurologist \_\_\_\_ Cardiac/pulmonary \_\_\_\_\_ GI/GU\_\_\_\_\_MSK\_\_\_\_\_

**DEPRESSION SCALE**

*Please fill out*

*Instructions: Circle the best answer for how you have felt over the past week*

1. Are you basically satisfied with your life? Yes or No
2. Have you dropped many of your activities or interests? Yes or No
3. Do you feel that your life is empty? Yes or No
4. Do you often get bored? Yes or No
5. Are you in good spirits most of the time? Yes or No
6. Are you afraid that something bad is going to happen to you? Yes or No
7. Do you feel happy most of the time? Yes or No
8. Do you often feel helpless? Yes or No
9. Do you prefer to stay home, rather than going out and doing new things? Yes or No
10. Do you feel you have more problems with memory than most? Yes or No
11. Do you think it is wonderful to be alive now? Yes or No
12. Do you have thoughts you be better off dead or of hurting yourself? Yes or No
13. Do you feel worthless the way you are now? Yes or No
14. Do you have energy? Yes or No
15. Do you have trouble falling or staying asleep, or sleeping too much? Yes or No
16. Do you have a poor appetite or overeating? Yes or No
17. Do you feel your situation is hopeless? Yes or No
18. Do you think most people are better off than you are? Yes or No

**ASSESSMENT/EVALUATION ~ Practitioner**

***Do not write below this area***

**Height: \_\_\_\_\_\_\_\_ Weight**: \_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HR\_\_\_\_\_\_\_\_\_\_BP\_\_\_\_\_\_\_\_\_\_ (sitting, side) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Temp \_\_\_\_\_\_\_\_\_\_ 02 Sat \_\_\_\_\_\_**

**Neuro/Psych**

Affect: worried

Appearance: casually dressed, wearing dark sunglasses for her photophobia

Approach: cooperative

Attention/Concentration: not tested.

Behavior: engaged

Cognition: draw clock

EPS /Tardive Dyskinesia: No involuntary movement noted or reported.

Eye Contact: good

Insight: fair

Judgment: Fair

Language: \_\_\_\_appropriate \_\_\_\_\_confused \_\_\_\_\_\_\_Other

Memory: not tested

Mood: “mostly happy” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor Activity: no psychomotor agitation or retardation observed, normal gait

Orientation X4

Speech: Normal rate and rhythm

**Thought Content:** Thinking is linear.

Delusions: \_\_\_\_\_\_\_\_\_none observed \_\_\_\_\_\_\_\_\_\_ other

**Cardiac/Pulmonary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**GI/GU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MSK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SKIN/HAIR/NAILS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLAN OF CARE/MEDICATIONS:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Risk/Benefits/Side Effects/Alternatives to proposed treatment discussed with client and

Medication Consent Form signed.

 Discussed need to present to clinic/urgent care/ER prior to follow-up appointment if symptoms worsen or side effects appear.

Discussed the importance of continued therapy.

Provided \_\_\_\_day supply of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lot# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp date \_\_\_\_\_\_\_\_\_\_\_\_

Provided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Potential impact of drugs and alcohol use on psychiatric symptoms discussed with client.

Labs: Ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Xrays, studies Ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results discussed with client: \_\_\_\_\_

Referral to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow-up at medication clinic in one-two months with prescriber \_\_\_\_\_One Month \_\_\_\_\_Two Months

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Lorraine Bonaldi, MSN, MBA, APRN, FNP-BC*

**CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ICD-10 Code(s):**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6.**

Rule outs/Differentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RESPONSIBILITY AGREEMENT**

***Please Read and Sign***

*Lorraine Bonaldi, APRN, FNP-BC* appreciates the confidence you have shown in choosing me to provide you your medical needs. I am committed to providing you with the highest quality healthcare. Please read and sign this for to acknowledge your understanding of your responsibility as a patient at *Caring Hearts & Minds*.

1. *Preparing for your appointment*: Please plan to arrive at your scheduled time for your appointment if face to face. This will give us ample time to get all patient information entered into your account, collect your co-pay, and have any necessary paperwork completed.
2. *Late arriving patients*: We reserve the right to request you reschedule your appointment if you arrive after your appointment time. Late arriving patients are disruptive to the practice and other patients.
3. *Missed appointments (No Shows):* Our policy is that you will be charged $75.00 for missed visits, whether tele-health or face to face appointments. If not cancelled 24 hours of your scheduled time. Please help us serve you better by keeping your regularly scheduled appointments or provide us the courtesy of canceling or rescheduling well in advance of the appointment. If we are unavailable to answer your call, please leave a detailed message.
4. *Disruptive Behavior:* Caring Hearts & Minds has zero tolerance for patients exhibiting disruptive behavior. Caring Hearts & Minds will not tolerate abusive patient displays of this type of behavior. And you will immediately be asked to leave the premises and reported to the appropriate authorities.
5. *Payment Policy:* All co-payments, co-insurance and deductibles are expected to be paid at the time service or prior service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from the patient can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. You are responsible for services denied by your insurance as not medially necessary or not covered. There are several patient responsibility components which may apply to an insurance payment.
6. *Insurance Charges:* You are responsible for notifying us immediately should your insurance change. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the resulting balance.
7. *Cash Payments:* Cash payments are accepted at an already-discounted rate and payment is due at the time of service
8. *Open Balance:* a $20.00 administrative feel will be added to each month a statement is sent due to an open balance.

*We reserve the right to dismiss patients from the practice who do to adhere to these patient responsibilities. Thank-you for your understanding the importance of keeping your appointment.*

Patient or Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

**CANCELLATION & NO-SHOW FEE**

***Policy that is required by ALL patients***

Missed or late cancelled appointments without a 24-hour notice will result in a ***$75.00*** no-show fee. This fee is separate charge which will not be covered by your insurance plan. You will need to pay this fee in full before you reschedule any future appointments.

*Caring Hearts & Minds* requires a debit/credit card or health savings account and signature on file as a method of payment. The card you provide us will be run if there is a balance due on your account. Balance dues include no-shows, cancellations without a 24-hour notice, deductibles, co-insurance, co-pays and charges not covered by insurance. A receipt can be sente to address upon request. I agree not to dispute the payment with my credit card company, so long as the transaction corresponds to the terms of *Caring Hearts & Minds*.

Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMEX/MC/VISA/DISCOVER Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

This notice/Signature serves as your consent to charge the balance due on account. We do not call-in advance. Under no circumstances other than the conditions mentioned above, will *Caring Hearts & Minds* charge your credit card. In conjunction with HIPAA regulations, all credit information will be kept confidential.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 24-hour’s notice affects the care we provide our other patients and the cost of care. Each no-show represents a missed opportunity for another *Caring Hearts & Minds* patient to see the provider.

I have read and understand Caring Hearts & Minds has a ***$75.00*** fee for any no-show and late cancellation. I agree to pay Caring Hearts & Minds no-show fees as stated above if I no-show or have not called Caring Hearts & Minds office at least 24 hours in advance to cancel my appointment.

Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_

**FINANCIAL CONTRACT/AGREEMENT**

1. I understand that if I do not pay my account with *Caring Hearts & Minds* in full that my account may be assigned to a collection agency for collection.
2. I understand that if my account is assigned to a collection agency that the collection agency will charge a commission or fee that may be as much as 40% of the amount I owe to *Caring Hearts & Minds*. I agree if my account is assigned to a collection agency’s commission or fee to the amount I woe to Caring Hearts & Minds and I agree to pay that additional amount.
3. I understand that the addition of a collection agency’s fee or commission to my unpaid balance may well result in my owing a sum substantially more than the amount owed under my agreement. I understand, for example, that if the unpaid balance that I owe to *Caring Hearts & Minds* may add up to $400 to my account and I agree to pay the sum $1,400 in such event.
4. I understand and agree that in the event of legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney’s fees.
5. I understand that without an authorization or refund from my HMP/PPO and/or primary care provider, I will be financially responsible for the charges I owe.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_

**MEDICARE (ONLY SIGN IF YOU HAVE MEDICARE)**

We accept Medicare. We will submit your claim to Medicare, but you will be responsible for any deductibles, co-insurance or ANY charges NOT covered by Medicare and/or your secondary insurance should you have one.

Secondary Insurance: this office will NOT file your secondary insurance. If your secondary insurance has not paid within 90 days pf the date of service, payment for services becomes the patient’s responsibility.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

**HIPAA RELEASE FORM- RELEASE OF INFORMATION**

I authorize the release of information including examination, diagnosis, and related records/information rendered to me and claims information. \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

The information may be released to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release will remain in effect until terminated by me in writing: (initial) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Messages:

Please call (check all that apply): If unable to reach me (check all that apply):

( ) my home ( ) my work ( ) you may leave a detailed message

( ) my cell phone ( ) please leave a message asking me to

 Return your call

 HIPPA (please check box)

 ( ) A notice of Privacy Practices has been offered to me or made available should I choose to take one.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL RECORDS RELEASE FORM**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/provider/person/facility/entity listed below.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_

The information you may release subject to this signed release form is as follows:

( ) ***Complete Records*** ( ) Progress notes

( ) Care plan ( ) Radiology reports

( ) Pathology reports ( ) Operative reports

( ) Hospital reports

( ) Office notes ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) History and Physical

( ) Lab reports

( ) Treatment records

( ) Medication records

Release my protected health information to the following facility:

Name: Caring Hearts & Minds, Lorraine Bonaldi, APRN, FNP-BC

Address: 1001 Pyramid Hwy Suite 206, Sparks, NV 89431

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_