

Patient Name _____ MRN _____ Date _____

Physical Exam Waiver

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, also referred to as an Annual Physical.

Please know that your insurance may only cover this service once every 365 days. If you have received this service from another provider in the last 375 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age focused history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs, and radiological services to identify potential problems.

The Annual Preventative visit does not include the below services. If you require these services today, please be aware your insurance may require that you pay a copay for today's visit. Please let your provider know if you do not want these services.

- Evaluation and or management of new or ongoing problems that would require further testing or discussion. This may include a more problem focused physical exam, ordering of diagnostic tests, prescription drug management, referring or discussing your case with another specialist, or simply providing counseling related to a known health issue.

If you have any questions regarding this information, please see the front desk staff.

I have read and understand this information:

Patient Signature _____ Date _____

SITE NAME

PRINT PATIENT NAME

PT DOB

Female

Male

DATE

MRN

SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. Please check all correct response(s) for each question.

1. On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
 0 days 1 day 2 days 3 days
 4 days 5 days 6 days 7 days
 Patient refused
2. On average, how many minutes do you engage in exercise at this level?
 0 min 10 min 20 min 30min 40min
 50min 60min 70min 80min 90 min
 100min 110min 120min 130min
 140min 150+min Patient refused
3. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
 Not hard at all Hard
 Not very hard Very hard
 Somewhat hard Patient refused
4. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
 Yes No Patient refused
5. In the last 12 months, how many places have you lived? _____
6. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now) ?
 Yes No Patient refused
7. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
 Yes No Patient refused
8. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
 Yes No Patient refused
9. Within the past 12 months, you worried that your food would run out before you got the money to buy more?
 Never true Sometimes true
 Often true Patient refused
10. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
 Never true Sometimes true
 Often true Patient refused
11. Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?
 Not at all Only a little
 To some extent Rather much
 Very much Patient refused
12. In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
 Never Once a week
 Twice a week Three times a week
 More than three times a week
 Patient refused
13. How often do you get together with friends or relatives?
 Never Once a week
 Twice a week Three times a week
 More than three times a week
 Patient refused
14. Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
 Yes No Patient refused
15. How often do you attend meetings of the clubs or organizations you belong to?
 Never 1 to 4 times per year
 More than 4 times per year
 Patient refused
16. Are you married, widowed, divorced, separated, never married, or living with a partner?
 Married Widowed Divorced Separated
 Never married Living with Partner
 Patient refused

Continued on next page

02/28/2023

SITE NAME

PRINT PATIENT NAME

PT DOB

Female

Male

DATE

MRN

SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. Please check all correct response(s) for each question.

17. Within the last year, have you been afraid of your partner or ex-partner?

Yes No Patient refused

18. How often do you have a drink containing alcohol?

Never Monthly or less
 2-4 times a month 2-3 times a week
 4 or more times a week
 Patient refused

19. How many drinks containing alcohol do you have on a typical day when you are drinking?

Patient does not drink 1 or 2
 3 or 4 5 or 6 7 to 9
 10 or more Patient refused

20. How often do you have six or more drinks on one occasion?

Never Less than monthly
 Monthly Weekly
 Daily or almost daily Patient refused

02/28/2023

Site Name _____



PRINT PATIENT NAME _____

PT DOB _____

Female

Male

MRN _____

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle 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 of have let yourself or your family down.	0	1	2	3
7. Trouble Concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. How difficult have those 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

Add column: _____ + _____ + _____

TOTAL: _____

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account # _____

Patient Name _____ DOB _____ Date _____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

By providing the below phone #(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail _____ (Phone #)

DO NOT RELEASE Information to the following people: _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____ Date _____

The information provided on this form will stay in effect until updated by the patient