Foothills Health & Wellness Center

New/Updated Patient Assessment

Last: _____ First: _____ Middle: _____ Preferred Name: _____

SS#: _____-_____-_____ Date of Birth: _____/_____/_____ Age:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ E-Mail: _____

PLEASE FILL ALL INFORMATION OUT

Gender: _____ Female _____ Male _____ Trans (Female to Male) _____ Trans (Male to Femle) _____ Gender Queer _____ Decline to Answer _____ Other

Sexual Orientation: _____ Straight _____ Lesbian or Gay _____ Bisexual _____ Something Else _____ Do Not Know _____ Decline to Answer

Preferred Pronoun: _____ UnKnown _____ Decline to Answer _____ He, Him, His _____Other _____ She, Her, Hers _____ They, Them, Theirs _____Ze, Hir

Marital Status: _____ Married _____ Divorced _____ Single _____ Widowed _____ Separated

Student Status: _____ Full-Time Student _____ Not a Student _____ Part-Time Student

Race: _____ Asian _____ Native Hawaiian _____ Black/African American _____ American Indian _____ White _____ More than one Race _____ Unreported

Ethnicity
Hispanic/Latino _____ Yes _____ No

Language
_____English _____ Spanish _____ Other

Do you have any Religious Affiliations? _____ Yes _____ No Type: _____

US Veteran
_____ Yes _____ No

Tobacco Use
_____ Yes _____ No

INSURANCE

☐ Medicaid: _____ ☐ Commercial: _____

☐ Medicare: _____ ☐ None (Self-Pay): _____

EMERGENCY CONTACT

Name of Person:_____ (Nearest Friend or Relative NOT living with you)

Phone:_____ Relationship to patient: _____

MEDICAL HOME

Are you receiving services from any other healthcare/mental health agency? _____ Yes _____ No

If Yes, please list agency: _____ Contact Name: _____

EMPLOYMENT STATUS (Please Check One)

☐ Full Time ☐ Part Time ☐ Retired ☐ Disable ☐ Not Employed ☐ Student

Job Title:_____ Company: _____ Age: _____

RESPONSIBLE PARTY (If different from patient)

Name: _____ Relationship to Patient:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Number: _____

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New/Updated Patient Assessment

Migrant Worker: _____ Migrant _____ Not a Farm Worker _____ Seasonal

HOUSEHOLD INCOME (To determine eligibility for our Sliding Fee Scale, even if you have insurance)

Number in Household: _____ Household Yearly Income Amount: $_____

Pharmacy

Pharmacy Name: _____(please inform us at anytime if this changes)

Location: _____ Phone #: _____

PATIENT CENTERED MEDICAL HOME MODEL-SELECTING OF PERSONAL CLINICIAN

As a patient, the first step in managing your own care is to choose a team of care providers that you wish to provide your care. Each care team is led by your own personal clinician:

Please select your clinician from the list below.

Michelle Kiser, ARNP _____ Chelsea Walker, ARNP _____ Travis Marshall, LCSW _____

In the event that your personal clinician is out of the office or unavailable, one of our other clinicians will provided the same quality care as your personal clinician.

If patient is a minor, please fill out guardian information below!!!

Guardian Name: _____ Date of Birth: ____/____/____ SS# ____-_____-_____

Patient Signature:_____ Date: _____

Witness Signature:_____ Date:_____