**Foothills Health and Wellness Center**

**New/Update Patient Assessment**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Zip Code:** \_\_\_\_\_\_\_\_\_\_\_ **Tobacco Use:** Yes / No **Are you a Migrant Farm Worker:** Yes/No

**If You are a Migrant Farm Worker Please Circle Type:** Seasonal Migrant Not a Farm Worker

**Employment Status ( Please Circle):** Full Time Part-time Retired Disabled Not Employed

**Job Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_ **U.S. Veteran**: Yes / No

**Gender**: \_\_\_\_\_\_ Male

\_\_\_\_\_\_ Female

\_\_\_\_\_\_ Transgender

**If Transgender (Please Circle):** Male/Female to Male Female/Male to Female Other

Decline to Answer

**Sexual Orientation (Please circle):** Straight (Not Lesbian or Gay) Lesbian or Gay Bisexual

Something Else Do Not Know

Decline to Answer

**Race:** African American: \_\_\_ Asian: \_\_\_ Hispanic: \_\_\_ White: \_\_\_ Native: \_\_\_ Other: \_\_\_\_\_\_\_\_\_

**Ethnicity:** Hispanic/Latino: Yes / No

**Language (Please Circle):** English Spanish Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status (Please Circle):** Married Divorced Single Legally Separated

**Emergency Contact**: (Please list the nearest friend or relative NOT living with you)

Name of person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Home:**

Are you receiving services from any other health/mental health agency? Yes:\_\_\_\_\_ No: \_\_\_\_\_

Please List Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party: (if different from patient)**

Name of person responsible for this account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ s

**Income: (to determine eligibility for our DISCOUNT program, even if you have insurance)**

Source (SSI, Wages, Food Stamps, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number in Household: \_\_\_\_\_\_\_\_

Self- Reported: Yes \_\_\_\_\_ No \_\_\_\_\_Household Yearly Income Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any Religious Affiliations?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advanced Directives:** Do you have an Advanced Directive such as a Power of Attorney, Living Will, etc.?

Yes:\_\_\_\_\_\_\_ No:\_\_\_\_\_\_\_\_

**Pharmacy- (please inform us if this changes)**

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 personal clinician from the list below.

Michelle Kiser, ARNP \_\_\_\_

Chelsea Walker, ARNP \_\_\_\_

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

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

**Thank you for choosing Foothills Health and Wellness Center**