WOODMAN PRIMARY CARE + WELLNESS + CSW

CLIENT DATA SHEET

DATE:

NAME (Last, First, Middle)		DATE OF BIRTH	☐ MALE ☐ FEMALE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	SOCIAL SECURITY NUMBER	
EMPLOYER NAME	WORK PHONE	COUNTY	
EMPLOYER ADDRESS	CITY	STATE	ZIP
Referring Provider	Referring Provider Phone		

RESPONSIBLE PARTY **If same as client check here ☐ and skip this section.** **If client is a minor check here ☐**

NAME (Last, First, Middle)		DATE OF BIRTH	☐ MALE ☐ FEMALE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	SOCIAL SECURITY NUMBER	
EMPLOYER NAME	WORK PHONE	COUNTY	
EMPLOYER ADDRESS	CITY	STATE	ZIP
Referring Provider	Referring Provider Phone		

PRIMARY INSURANCE

POLICY HOLDER NAME	INSURANCE COMPANY	Relationship To Client ☐ SELF ☐ SPOUSE ☐ CHILD/PARENT
Holder's SS#	Holder's DOB	
Policy #	Group #	Effective Date

SECONDARY INSURANCE

POLICY HOLDER NAME	INSURANCE COMPANY	Relationship To Client ☐ SELF ☐ SPOUSE ☐ CHILD/PARENT
Holder's SS#	Holder's DOB	
Policy #	Group #	Effective Date

EMERGENCY CONTACT

NAME (Last, First, Middle)	Relationship to Client ☐ Spouse ☐ Parent ☐ Brother ☐ Sister ☐ Relative ☐ Other	
Contact Home Phone	Contact Cell Phone	# Where message can be left

I authorize my insurance benefits to be paid directly to Wellness, Woodman Primary, and/or CSW. I understand that I am financially responsible for all charges and/or fees not covered or otherwise paid by insurance and it is my responsibility to report any changes in insurance coverage. I hereby authorize release of all information necessary to secure payment of benefits. Wellness, Woodman Primary and CSW reserves the right to terminate treatment. I authorize the use of this signature on all insurance submissions. In the event my account remains unpaid for a period greater than 90 days, I authorize release any required information to a third party collection agency for the purpose of securing payment for services rendered.

_____ Client or Responsible Party Signature _____ Date

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CONSENT FOR TREATMENT/SERVICES

Client: _____ DOB: _____

I give my consent for medical, mental health and/or substance abuse/addiction treatment through:

Wellness Card LLC Woodman Primary Care LLC CSW

The professional and support staff members are trained to provide appropriate treatment / services as needed. I have read and understand the information regarding consent for treatment and services provided in the Client Policy Manual. (Additional copies available by request at Check-In desk) I have also received a copy, have read and understand the following:

- Fee schedule.
- Program Rules and Expectations.
- Consent for Disclosure.
- Client Rights Policy and Grievance Procedure.
- Education Materials
- Confidentiality of client records as required by 42 CFR, Part 2.

Client Signature: _____ Date: _____

Legally Responsible Person Name/Signature: _____ Date: _____

Staff Signature/Credentials: _____ Date: _____

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BENZODIAZEPINE/STIMULANTS

In the course of my treatment, the doctors may prescribe medications that have special instructions, random urine screens, pill counts and limited availability. If during treatment, benzodiazepines or other stimulants are prescribed, I have read and understood this policy and the additional information in the Client Orientation Packet.

I, _____, understand that I may be prescribed a benzodiazepine (i.e. Xanax, Valium, Ativan, Klonopin) and/or a Stimulant (i.e. Ritalin, Adderall, etc.) to address my current medical needs.
This medication can be addictive if taken over a long period of time; therefore, the goal of this medication is for short-term use until other non-addictive medications and therapeutic skills can be taught to address my medical condition.

A doctor must be seen in order for medication to be given. By agreeing to take these medications, I understand that any sudden discontinuation of this medication could lead to harmful medical conditions. Non-compliance to this agreement could lead to a sudden discontinuation of the medications. If this would occur, go to the nearest Emergency Room.

If I fill a prescription for benzodiazepine/stimulants from any other physician, other than the doctor being seen at Wellness, I understand that I will be permanently terminated from this agency.
I have read this agreement in full, and understand all requirements and will comply with the above statement.

☐ **I AGREE TO TAKE BENZODIAZEPINE/STIMULANTS**

_____ _____

Client Signature Date

WOODMAN PRIMARY CARE + WELLNESS + CSW

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

1. The following programs are authorized to: Disclose, Receive, or Exchange information as noted below:

FROM: ☒ **Wellness** ☒ **Woodman Primary** ☒ **CSW** ☐ **Primary Care Physician**

☐ **Other** _____
(Name, Address, City State Zip)

TO: ☒ **Wellness** ☒ **Woodman Primary** ☒ **CSW** ☐ **Primary Care Physician**

☐ **Other** _____
(Name, Address, City State Zip)

2. Purpose of Disclosure: ☐ Coordinate treatment, ☐ Treatment planning, ☐ **O**ngoing treatment,

☐ Other purposes (specify)_____.

3. Type of Information to be Disclosed: ☐ Progress Notes, ☐ **D**iagnostic Assessment, ☐ **T**reatment Summary, ☐ Lab/Urine Tests, ☐ Pregnancy Testing, ☐ Diagnosis, ☐ **A**ttendance ☐ Face Sheet, ☐ ER Records, ☐ History & Physical, ☐ Medication Records, ☐ Psychiatric Evaluation**,** ☐ Discharge Summary, ☐ School Information, ☐ Behavioral Health/Psychological Consult, ☐ Psychological Eval/Testing ☐ Substance Abuse Treatment, ☐ Psychosocial Assessment, ☐ Other (Specify)_____

4. Time Period to be Disclosed: ☐ Previous three months, ☐ Most recent appointment, ☐ One year

☐ Other information (specify) _____

5. I understand that:

- **I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.**
- I may cancel this authorization by submitting a ***written*** request except where a disclosure has been made in reliance on my prior authorization.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- Under Federal law, you do not have to allow us to receive the private notes from your counseling sessions with a mental health professional. If your information is given to others as allowed in the form, federal privacy laws may not protect it. Also, if you have allowed information to go to an insurance company to obtain coverage, the insurance company may still have the legal right to use the information.
- Unless otherwise revoked, this authorization will expire in 365 days from the date signed.

I authorize the name(s) or entities disclosed above to release verbally or in writing, information regarding any medical, mental health, alcohol and/or drug abuse diagnosis and/or treatment recommended or rendered to the identified patient. I understand that I may revoke consent at any time in writing.

☐ **I have read, understood and affirm the information regarding consent to disclose and I agree to abide by the above requirements**

✕_____ _____
Client Signature or Legal Representative/Guardian Date

_____ _____
→ Staff Signature/Credentials Date

WOODMAN PRIMARY CARE + WELLNESS + CSW

CLIENT MEDICAL HISTORY

_____ _____ _____

Client Name Date of Birth Date

Current Medical Problems: (Please check the box by all current medical problems.)

☐ Abdominal Pain	☐ Frequent Earaches	☐ Nausea
☐ Bedwetting	☐ Frequent Sore Throat	☐ Night Sweats
☐ Black or Bloody Stool	☐ Frequent Urination	☐ Poor Appetite
☐ Chest Pain	☐ Glasses or Contacts	☐ Sinus Pain
☐ Constipation	☐ Headaches	☐ Sleep Problems
☐ Coughing Blood	☐ Hearing Aid	☐ Special Diet
☐ Difficulty Swallowing	☐ Hearing Problems	☐ Trouble Breathing
☐ Dizziness	☐ Heart Murmurs	☐ Vision Problems
☐ Ears Ringing	☐ Heart Racing	☐ Vomiting
☐ Fatigue	☐ Heart Skipping a Beat	☐ Weight Loss
☐ Frequent Cough	☐ Hemorrhoids	☐ Weight Gain
☐ Frequent Diarrhea	☐ Other:	

Past Medical Problems: (Please list family members affected – i.e. Mother, Brother, Grandfather, etc.)

Medical Problem	Self	Family Member	Medical Problem	Self	Family Member
AIDS			Liver Disease		
Anemia			Measles		
Arthritis			Meningitis		
Asthma			Mental Illness		
Bronchitis			Mumps		
Cancer			Pancreatic Disease		
Chicken Pox			Pneumonia		
Diabetes			Polio		
Emphysema			Rheumatic Fever		
Gallbladder Disease			Scarlet Fever		
Hay Fever			Seizures		
Head Injuries			Stroke		
Heart Disease			Thyroid Disease		
Hepatitis			Tuberculosis		
High Blood Pressure			Ulcers		
HIV			Venereal/STD		
Kidney Disease			Other		

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ **YES**, provide copy please ☐ **NO**, request assistance if required.

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ **NO** ☐ **YES**

Please provide your Primary Care Physician information:

_____ _____

PHYSICIAN'S NAME LOCATION and/or NAME OF PRACTICE

_____ _____

STREET ADDRESS CITY STATE ZIP

_____

PHONE

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NOTE: Complete this page only if you have a Primary Care Provider (PCP).

COORDINATION OF CARE AND RELEASE OF INFORMATION

Communication between health care providers, your primary care physician (PCP), other health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your health care provider to share protected health information (PHI) with your other providers. This information will not be released without signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Client Rights

- You may end this authorization at any time by contacting the practitioner's office in writing.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization and if you choose not to agree with this request, your services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing, information regarding any medical, mental health and/or alcohol drug abuse diagnosis and/or treatment recommended or rendered to the following identified patient. I understand these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

_____ is authorized to release protected health information related to
Current Provider Name – Please Print

the evaluation and treatment of _____ _____.
Client Name Date of Birth

Primary Care Provider: _____
Name (See additional Information on previous page)

Additional Provider Name: _____

_____
Address City State Zip

☐ **I hereby refuse to give authorization for any release of information**

_____
Signature of Patient, Parent, Guardian or Authorized Representative * Date

* If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under Ohio law.

WOODMAN PRIMARY CARE + WELLNESS + CSW

MEDICAL HISTORY

_____ _____ _____

Client Name Date of Birth Date

Drug Sensitivity/Allergies: ☐ Unknown ☐ No ☐ Yes (Please List): _____

Any Adverse Reactions to: ☐ Latex ☐ Balloons ☐ Rubber Gloves ☐ Band-Aids ☐ Elastic Bandages

☐ Other: _____

Birth Defects: ☐ No ☐ Yes (Please List): _____

Date of Last Physical: _____ Date of Last Tetanus Shot: _____

CHILDREN AND ADOLESCENTS ONLY IMMUNIZATION RECORD: Are your vaccines up to date? ☐ Yes ☐ No

Immunization	Date							
DPT								
DT								
Polio								
MMR								
TB Test								
Other								

PAST HOSPITALIZATION: (please list all hospitalization, surgeries, serious injuries, or broken bones)

Date	Reason	Hospital

SUBSTANCE ABUSE HISTORY: (Please complete to the best of your knowledge)

Type of Substance	Age of First Use	Age of Regular Use	Date of Last Use	How?

Is there a family history of alcoholism or drug addiction or treatment? ☐ No ☐ Yes ☐ Addiction ☐ Treatment

Have you ever used drugs intravenously? ☐ No ☐ Yes Do you use tobacco products? ☐ Yes ☐ No Amount per day _____

Have you ever had or experienced: ☐ DT's ☐ Blackouts ☐ Shakes ☐ Seizures when using

Do you drink beverages with caffeine? ☐ No ☐ Yes Amount per day _____

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MEDICATION HISTORY

_____
Date

_____ _____
Client Name **Date of Birth**

_____ _____ _____
Prescribing Doctor Name **Practice** **Phone**

_____ _____ _____
Pharmacy Name **Location** **Phone**

Please list the name of each medication you take, the reason you take it, the dose, and the time you take it. In the last column, write down the side effects or any special instructions the prescribing doctors or pharmacists have told you. List all prescription medications and all over-the-counter medicines including vitamins or other nutritional supplements, pain relievers, antacids, laxatives and herbal remedies.

Name of Medication	Reason Taken	Dosage	Time Taken	Side effects/ Special Instructions

I certify all statements made in this medical history are, to the best of my knowledge, factual and complete. I further authorize Wellness, Woodman Primary, CSW or its designated representatives to contact listed physicians to verify history. Further permission is hereby granted to contact the Primary Care Provider or Referring Physician to share pertinent information related to my treatment.

×_____ _____
Client or Parent/Guardian Signature Date

WOODMAN PRIMARY CARE + WELLNESS + CSW

MEDICAL HISTORY

_____ _____

Client Name Date of Birth

For Males Only:

Do you have any discharge through your urethra? ☐ No ☐ Yes

Do you have prostate problems? ☐ No ☐ Yes

Do you have any problems with: ☐ Impotence ☐ Premature Ejaculation ☐ Orgasm

If yes, please explain: _____

_____

For Females Only:

Number of pregnancies? _____ Are you pregnant now? ☐ No ☐ Yes ☐ Maybe

Do you plan to become pregnant during the course of your treatment? ☐ No ☐ Yes ☐ Maybe

How many children do you have? _____ Abortion? ☐ No ☐ Yes Miscarriage? ☐ No ☐ Yes

Any complications with pregnancy? ☐ No ☐ Yes

If yes, please explain: _____

Do you have your period regularly? ☐ No ☐ Yes ☐ N/A Date of last menstrual cycle? _____

Do you have any: ☐ Vaginal Discharge ☐ Vaginal Itching ☐ Pain During Intercourse

If yes, please explain: _____

_____

Do you currently use birth control? ☐ No ☐ Yes Name: _____

Contact Information:

Wellness, Woodman Primary and CSW has a policy of making reminder calls for your next appointment. Our staff may need to call you if a medical emergency arises.

What phone number is the best number to reach you? # _____

What time of day is best to reach you? _____

If you have an answering system:
A message with your first name, appointment day and time information will be left.

If you do not want to be notified by phone (except for emergencies) please check here. ☐