Lincoln Family Wellness, P.C.

Michelle K. Manning, M.D. • Janet K. Sellon, M.D. • Timothy J. Dalton, M.D. • C. Kyle Haefele, M.D.
Benjamin Biehl, M.D. • Rebecca L. Pfabe, A.P.R.N. • David A. Foster, A.P.R.N. • Penny Placke, P.A.

1101 South 70th Street Suite 101
Lincoln, NE 68510

FAMILY HISTORY *ATTACH LIST IF NEEDED*

Family Member	Current Age	Age of Death	Cancer	Heart	Stroke	Diabetes	Other
Father							
Mother							
Sibling M or F							
Sibling M or F							
Child M or F							
Child M or F							

SOCIAL HISTORY

Marital Status:______________________ **Occupation:**______________________

Tobacco/Nicotine Use

☐ Current Type:______________________ How much per day:______________

☐ Past Type:______________________ How much per day:______________ Quit Date:____________

☐ Not Applicable

Second Hand Smoke Exposure

☐ Current ☐ Past ☐ Not Applicable

Drug Use

☐ Current Type:______________________

☐ Past Type:______________________ Quit Date:__________________

☐ Not Applicable

Alcohol Use

☐ None in the past 12 months

☐ Current How often: ______________________ How many at a time:______________________

Ever more than 6 on one occasion and if so how often: ______________________

Caffeine Intake

☐ Yes How often:______________________ How many at a time:______________________

☐ No

Exercise

☐Yes How often:______________________ Type:______________________

☐No

HEALTH MAINTENANCE HISTORY **ATTACH IMMUNIZATION LIST IF AVAILABLE**

Test	Date	Facility	Results
Pap Smear			
Mammogram			
Colonoscopy			
PSA			
Bone Density			

PLEASE COMPLETE BOTH SIDES.

ARRIVE 15 MINUTES PRIOR TO SCHEDULED APPOINTMENT TIME WITH YOUR PHOTO ID AND INSURANCE CARD

Lincoln Family Wellness, P.C.

Michelle K. Manning, M.D. • Janet K. Sellon, M.D. • Timothy J. Dalton, M.D. • C. Kyle Haefele, M.D.
Benjamin Biehl, M.D. • Rebecca L. Pfabe, A.P.R.N. • David A. Foster, A.P.R.N. • Penny Placke, P.A.

1101 South 70th Street Suite 101
Lincoln, NE 68510

Full Name: ______________________________ DOB:__________ Date:__________

HEALTH HISTORY FORM

ALLERGIES ☐ No Allergies

Allergy	Allergic Reaction

MEDICATIONS/SUPPLEMENTS *ATTACH LIST IF NEEDED*

Medication (including strength)	Dose	Times Per Day

SURGERIES/HOSPITALIZATIONS *ATTACH LIST IF NEEDED*

Reason	Year	Surgeon	Facility

PERSONAL MEDICAL HISTORY

Disease/Condition	Current	Past
ADHD/ADD		
Alcoholism		
Asthma		
Cancer		
Depression/Anxiety		
Diabetes		
COPD/Emphysema		
Heart Disease		

Disease/Condition	Current	Past
High Cholesterol		
Thyroid Disease		
Renal (Kidney) Disease		
Migraine Headaches		
Sleep Apnea		
Stroke		
OTHER:		

SPECIALISTS *ATTACH LIST IF NEEDED*

Specialist Type	Specialist Name	Last Visit

PLEASE COMPLETE BOTH SIDES.

ARRIVE 15 MINUTES PRIOR TO SCHEDULED APPOINTMENT TIME WITH YOUR PHOTO ID AND INSURANCE CARD

Patient Information Form

Name: ______________________________Preferred Name____________Date of Birth________________

Sex: _______________________ Social Security # ____

Address: ____

City: ____________________ State:__________Zip:__________________________

Home Phone Number: _____-_____-______ Cell Phone Number: ___-___-____

Work Phone Number: _____-_____-_______

Email Address: ____

Employer: ____

Race______________________________Ethnicity____

Preferred Language____

Preferred Pharmacy____

Guarantor/Responsible Party Name (if different): ____

Guarantor Address: ____

Insurance Type: ____

Policy ID: ___________________________ Group Number: __________________________

Policy Holder: ______________________________Policy Holder Birthdate_______________

Emergency Contact:____

Relation to patient: _______________________ Phone Number: ___-___-____

Authorization for Release of Information to Family Members

Patient Name:____DOB:____________

SSN:__________________ Address:____

Contact Phone Number:_____________________

I,_____________________________________(Patient Name), direct Lincoln Family Wellness, PC to disclose and release my protected health information described below to:

Name:_____________________________________ Relationship:_____________________

Address:____________________________________ Contact Phone Number:____________

Health Information to be disclosed upon the request of the person named above:

☐ **Disclose** my complete health record (including but not limited to diagnosis, test results, medications, plan of treatment and billing for all conditions).

☐ **Disclose** my health record, as above, **But DO NOT disclose** the following (check all that apply):

- ☐Mental health records
- ☐Communicable diseases (including HIV and AIDS)
- ☐Alcohol/drug abuse treatment
- ☐Other (please Specify): ____

The authorization shall be effective until revoked. This includes all past, present and future periods unless otherwise specified.

You may revoke this authorization in writing at any time by notifying our office, preferably in writing.

Patient/Guardian Signature:_________________________________ Date:_________________

Patient Health Questionnaire and General Anxiety Disorder
(PHQ-9 and GAD-7)

Date______________ Patient Name:______________________________ Date of Birth: ____________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	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 or 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 in some way.	0	1	2	3

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all	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

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
No permission required to reproduce, translate, display or distribute, 1999.

OVER

Barriers

Date: ____________ Name: ____ Date of Birth: ____________

1. **What is your housing situation today?**
   a. I do not have housing [I am staying with others, hotel, shelter, on the street, in a car, abandoned building, bus, train station, or city park.]
   b. I have housing today, but I am worried about housing in the future.
   c. I have housing.
2. **Think about the place you live. Do you have problems with any of the following? (Circle all that apply)**
   a. Bug infestation
   b. Mold
   c. Lead paint or pipes
   d. Inadequate heat
   e. Oven or stove not working
   f. No or not working smoke detectors
   g. Water leaks
   h. None of the above
3. **Within the past 12 months have you had worries that your food would run out before you have the money to buy more? Do you worry about how you will get meals?**
   a. Yes
   b. No
4. **In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   a. Yes
   b. No
5. **In the past 12 months, has the electric, gas, or water company threatened to shut off services?**
   a. Yes
   b. No
6. **How often does anyone, including family, physically hurt you?**
   a. Never
   b. Rarely
   c. Sometimes
   d. Fairly often
   e. Frequently
7. **How often does anyone, including family, threaten, curse, scream, or talk down to you?**
   a. Never
   b. Rarely
   c. Sometimes
   d. Fairly often
   e. Frequently
8. **Is communicating with others difficult for you?**
   a. Yes, I need a translator to communicate with English speakers.
   b. Yes, other communication barrier.
   c. No
9. **Would you like to receive information about resources that can help with any of the above needs?**
   a. Yes
   b. No
10. **<u>AGE 65 AND UP.</u> In the last 12 months, have you had any falls?**
    a. Yes. How many times? __ Any injuries associated with with falls? YES / NO
    b. No