Patient Name:____________________ DOB: _________________________

FIRST POINT URGENT CARE INC.

18 & Older Immigration Screening Form

First Name: _____________________________ Middle Name: _______________ Last Name: ____________________

Date of Birth: ___________________________

Place of Birth (City/Town/Village): ____

Country of Birth:____

Current U.S. Address:____

City: ____ State: _____________ Zip Code: _________________________

Alien Registration Number A- _____________________________________

USCIS Online Account Number(if any): ________________________________

Cell Phone Number: _________________________________ Home Phone Number: ___________________________

Work Phone Number: ________________________________ Email: ____

Person completing this form:

☐ Self

☐ Other (complete information below)

First Name: ___________________________ Middle Name: _______________ Last Name: ______________________

☐ Same contact information as patient (if not then complete info below):

Current U.S. Address: ____

City: ____State: ______________Zip Code: _________________________

Cell Phone Number: ____________________________________ Home Phone Number: ____________________________

Relationship to patient: _________________________________

Race: ☐ Asian ☐ Black ☐ White ☐ Other

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to disclose ☐ Other

Marital Status: ☐ Married ☐ Single

Patient Name:____________________ DOB: _________________________

I authorize First Point Urgent Care to correspond with me with email that is NOT encrypted and not HIPAA Compliant (circle one) True False

Please initial below:

________ I have been given the opportunity to read the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_________ I have read, understand, and agree to the Payment Policy outlined by First Point Urgent Care (FPUC).

Sharing of Medical Information.

****Note: If the following information is left blank, we cannot share medical information with any person.*

I authorize First Point Urgent Care to discuss my medical health information with:

First Name:_______________________________________ Last Name: ______________________________________

Date of birth:_____________________________________ Relationship: _____________________________________

Are you, or is there a chance you may be pregnant?*

___I am pregnant
___I am not pregnant
___I am unsure if I am pregnant
___Not applicable

Patient Name:____________________ DOB: _________________________

Past Medical History (required):

History of tuberculosis vaccine: Yes ☐ No ☐

History of latent tuberculosis: Yes ☐ No ☐

History of tuberculosis treatment: Yes ☐ No ☐

History of positive tuberculosis skin test: Yes ☐ No ☐

History of syphilis: Yes ☐ No ☐

History of gonorrhea: Yes ☐ No ☐

History of substance abuse: Yes ☐ No ☐

History of behavioral health medication: Yes ☐ No ☐

History of behavioral health admission: Yes ☐ No ☐

History of behavioral health counseling: Yes ☐ No ☐

History of Hansen's (skin) disease: yes ☐ No ☐

History of Leprosy: Yes ☐ No ☐

If "yes" to any health history questions above, please provide date(s):

____

____

____

Surgical History (Type of Surgery/Reason and Year):

____

____

____

Medication Allergies (Name of Medication/Product and Reaction):

____

____

____

Medications/Supplements (Name, Strength and Frequency):

____

____

____

____

Other Providers you see (Name, Phone# and Specialty):

____

____

____

____

Current Primary Care Physician (Name and Phone#):

____

Signature: _____________________________________

Printed Name: _________________________________

Today's Date: __________________________________

Patient Name:_____________________ DOB: __________________________

Alcohol consumption screening AUDIT questionnaire:

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

___Never (0 points)
___Monthly or less (1 point)
___2 to 4 times a month (2 points)
___2 to 3 times a week (3 points)
___4 or more times a week (4 points)

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

___1 or 2 (0 points)
___3 or 4 (1 point)
___5 or 6 (2 points)
___7 to 9 (3 points)
___10 or more (4 points)

3. How often do you have 5 or more drinks on one occasion?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

___Never (0 points)
___Less than monthly (1 point)
___Monthly (2 points)
___Weekly (3 points)
___Daily or almost daily (4 points)

9) Have you or someone else been injured as a result of your drinking?*

___No (0 points)
___Yes, but not in the last year (2 points)
___Yes, during the last year (4 points)

10. Has a relative, a friend, a doctor, or another health worker been concerned about your drinking or suggested you cut down?*

___No (0 points)
___Yes, but not in the last year (2 points)
___Yes, during the last year (4 points)

Initials: _______________________________ Today's Date: ___________________________

Patient Name:____________________ DOB: _________________________

The Drug Abuse Screening Test (DAST):

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

1. Have you used drugs other than those required for medical reasons? Yes ☐ No ☐
2. Have you abused prescription drugs? Yes ☐ No ☐
3. Do you abuse more than one drug at a time? Yes ☐ No ☐
4. Can you get through the week without using drugs (other than those required for medical reasons)? Yes ☐ No ☐
5. Are you always able to stop using drugs when you want to? Yes ☐ No ☐
6. Do you abuse drugs on a continuous basis? Yes ☐ No ☐
7. Do you try to limit your drug use to certain situations? Yes ☐ No ☐
8. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes ☐ No ☐
9. Do you ever feel bad about your drug abuse? Yes ☐ No ☐
10. Does your spouse ever complain about your involvement with drugs? Yes ☐ No ☐
11. Do your friends or relatives know or suspect you abuse drugs? Yes ☐ No ☐
12. Has drug abuse ever created problems between you and your spouse? Yes ☐ No ☐
13. Has a family member sought help for problems related to your drug use? Yes ☐ No ☐
14. Have you ever lost friends because of your use of drugs? Yes ☐ No ☐
15. Have you neglected your family because of your use of drugs? Yes ☐ No ☐
16. Have you ever been in trouble at work because of drug abuse? Yes ☐ No ☐
17. Have you ever lost a job because of drug abuse? Yes ☐ No ☐
18. Have you gotten into fights when under the influence of drugs? Yes ☐ No ☐
19. Have you ever been arrested while under the influence of drugs? Yes ☐ No ☐
20. Have you ever been arrested for driving while under influence of drugs ? Yes ☐ No ☐
21. Have you engaged in illegal activities in order to obtain drug? Yes ☐ No ☐
22. Have you ever been arrested for possession of illegal drugs? Yes ☐ No ☐
23. Have you experienced withdrawal as a result of heavy drug intake? Yes ☐ No ☐
24. Have you had a medical problems as a result of your drug use ? Yes ☐ No ☐
25. Have you ever gone to anyone for help for a drug problem? Yes ☐ No ☐
26. Have you ever been hospitalized due to related to drug use? Yes ☐ No ☐
27. Have you ever been in a treatment programs due to related to drug use? Yes ☐ No ☐
28. Have you been treated as an outpatient for due related to drug abuse? Yes ☐ No ☐

Initials: ____________________________ Today's Date: ____________________________

Patient Name:____________________ DOB: _________________________

Modified Mini Screen (MMS)

Please choose "Yes" or "No" for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks ? Yes ☐ No ☐

2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Yes ☐ No ☐

3. Have you felt sad, low, or depressed most of the time for the last two years? Yes ☐ No ☐

4. In the past month, did you think that you would be better off dead or wish you were dead? Yes ☐ No ☐

5. Have you ever had a period of time when you were feeling up, hyper, or so full ofenergy or full of yourself that you got into trouble, or that other people thought you were not your usual self?(Do not consider times when you were intoxicated on drugs or alcohol.) Yes ☐ No ☐

6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were to act this way?

Yes ☐ No ☐

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is “yes,” check “yes” ;otherwise check “no.”)

Yes ☐ No ☐

8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: ● being in a crowd, ● standing in a line, ● being alone away from home or alone at home, ● crossing a bridge, ● traveling in a bus, train, or car?

Yes ☐ No ☐

9. Have you worried excessively or been anxious about several things over the past six months?(If you answer “no” to this question, answer “no” to Question 10 and proceed to Question 11.)

Yes ☐ No ☐

10. Are these worries present most days? Yes ☐ No ☐

11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: ● speaking in public, ● eating in public or with others, ● writing while someone watches, ● being in social situations.

Yes ☐ No ☐

Patient Name:____________________ DOB: _________________________

Continued on next page…

12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples:● being afraid that you would act on some impulse that would be really shocking, ● worrying a lot about being dirty, contaminated, or having germs, ● worrying a lot about contaminating others, or that you would harm someone even though you didn't want to, ● having fears or superstitions that you would be responsible for things going wrong, ● being obsessed with sexual thoughts, images, or impulses, ● hoarding or collecting lots of things, ● having religious obsessions.

Yes ☐ **No** ☐

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples: ● washing or cleaning excessively, ● counting or checking things over and over, ● repeating, collecting, or arranging things, ● other superstitious rituals.

Yes ☐ **No** ☐

14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: ● serious accidents, ● sexual or physical assault, ● terrorist attack, ● being held hostage, ● kidnapping, ● fire, ● discovering a body, ● sudden death of someone close to you, ● war, ● natural disaster.

Yes ☐ **No** ☐

15. Have you re-experienced the awful event in a distressing way in the past month? Examples:● dreams, ● intense recollections, ● flashbacks, ● physical reactions.

Yes ☐ **No** ☐

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?

Yes ☐ **No** ☐

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?

Yes ☐ **No** ☐

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?

Yes ☐ **No** ☐

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?

Yes ☐ **No** ☐

Patient Name:____________________ DOB: _________________________

20. Have your relatives/friends ever considered any of your beliefs strange or unusual? **Yes** ☐ **No** ☐

21. Have you ever heard things other people couldn't hear, such as voices? **Yes** ☐ **No** ☐

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see ?

Yes ☐ **No** ☐

Initials: ___________________________ Today's Date: ____________________________