Office Use Only
Client Account Number:________________

NEW CLIENT INFORMATION

Name: ____
First Middle Last Preferred/Goes by

Date of Birth: _______________ Social Sec #: ________-______-_________ Gender: _____________
(Format mm/dd/yyyy)

Current Address: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

(OK to mail correspondence?) Yes___ No___

Please only give phone numbers where we may leave a message.

Home Phone: (___) ________________________

Work Phone: (___) ________________________

Cell Phone: (___) ________________________

Other Phone: (___) ________________________

Calling Instructions

____

____

Emergency: (___) ____________ Name: ______________________Relationship: ________________

County:
01__Ramsey
02__Hennepin
03__Dakota
04__Anoka
05__Washington
06__Other

Education: Highest Grade Completed:
01___Less than High School
02___High School
03___College
04___Trade/Vocational School
05___Graduate School

Relationship Status:
01___Single
02___Married
03___Separated
04___Divorced
05___Widowed
06___Domestic Partnership

Race:
01___American Indian or Alaskan Native
02___Asian
03___African American or Black
04___Native Hawaiian/Pacific Islander
05___Caucasian
06___Decline to Answer

Ethnicity:
07___Hispanic or Latino
08___Not Hispanic or Latino

Veteran Status: Yes___ No___
Active Duty: Yes___ No___

Preferred Language: ____________________________
Country of Origin: ______________________________

Are you: Employed ___Y___N Where: ____
_______Not Currently Employed
_______Not Currently Employed and Not Searching
_______Are you currently a student?

Primary Care Provider:

Name: ____

Address: ____
Street City State Zip

Phone: _________________________________ Fax: ________________________________

Referral Information: Same as Above? Yes___ No___ Phone Number: ______________________
Referring Doctor Name: ____________________________________

Preferred Pharmacy:

Name: ____

Address: ____
Street City State Zip

Phone: _________________________________ Fax:________________________________

Do you have insurance? **Yes___ No___**

Primary Insurance Information:

Insurance Company: _________________________ Phone Number: _____________________

Policy #:__________________________________Group #:___________________________

Name of Insured: ___________________________ Insured's Date of Birth: ______________
First Last

Secondary Insurance Information:

Insurance Company: _________________________ Phone Number: _____________________

Policy #:__________________________________Group #:___________________________

Name of Insured: ___________________________ Insured's Date of Birth: ______________
First Last

AUTHORIZATION TO BILL INSURANCE

I authorize the payment of benefits for which I am entitled from my insurance company to be made directly to Hamm Clinic.

__________________________________ ____________________
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES

I have received the notice of privacy practices which outline the Health Insurance Portability and Accountability Act (HIPAA) Standards.

__________________________________ ____________________
Signature Date

[ ] File as Health & Personal History
[ ] File as Psychiatry Review of Systems

HEALTH AND PERSONAL HISTORY FORM

Client Name: ________________________ Client Account Number: ______________

Date of Birth:_________________________ Today's Date:______________________

Please fill in such information as you know, or have readily at hand

Healthcare Information

Who is your primary physician/clinic? ______________________________________
When was your last checkup/visit? ____

List all current Medications

**Please list medications:*
vitamins, and supplements:

____
____
____
____

Psychiatry Medications, if any

____
____
____
____

Any drug or other allergies? **Y N**
List if known ____
____

Any serious childhood illness? **Y N**
____
____

Any adult illnesses or infections? **Y N**
____
____

Any Surgeries? **Y N**
____
____

Any illness in Family/relatives? **Y N**
____
____

Current Physical Concerns (review by "systems")

1) Weight change/fevers: **Y N**
Overall Health/Nutrition? ____
____

2) Problems with eyes/vision? **Y N**
____
____

3) Problems with ears/hearing? **Y N**
____
____

4) Nose/throat/sinus trouble? **Y N**
____
____

5) Chest, asthma, lung concern? **Y N**
____
____

Smoking, if any? **Y N**
____

6) Heart, high blood pressure? **Y N**
____
____

Hearth Rhythm disorder? **Y N**
____

7) Stomach, bowel, digestion? **Y N**
____
____

8) Kidney or bladder concerns? **Y N**
____
____

9) [Women] Pregnancy, delivery? **Y N**
____
Pelvic/breast exam? **Y N**
____

[Men] Prostate Trouble? **Y N**
____

10) Any sexual concerns? **Y N**
____

11) Diabetes, thyroid, endocrine trouble? **Y N** ______________________________
*Cholesterol or lipid concerns? **Y N** ______________________________

12) Bone, joint pain, arthritis? **Y N**
____
____

13) Headaches, dizziness, stroke? **Y N** ____________________________________
*Head Injury or trauma? **Y N** ____________________________________

14) Bleeding, anemia, or cancer? **Y N**
____
____

15) Skin rash, cuts or bruises? **Y N**
____
____

16) Any other health concerns? **Y N**
____
____
____

For our Physician/Nurse, as needed:

Pulse _________________________

BP____________________________

R ____________________________

Weight/BMI ____________________

Gait/Station ___________________

Motor Strength/Tone ___________

____
Reviewed & Discussed **Date**

Office Use Only
Client Account Number:______________________________
Client Name : ___________________________________
Date: ____

Family and Household Background

Family of Origin and Childhood Family Household

First Name	Current Age	Relationship to you	Lived with you?	Occupation	Education	Date if deceased

Primary Language spoken in your childhood home, if not English:_________________________________

Are/were mental health or chemical use issues a problem for someone in this group? Briefly Explain.

____

____

____.

Current Family and Household

First Name	Age	Relationship to you	Lived with you?	Occupation Or Grade

Primary Language spoken in your home, if not English:_________________________________

Are/were mental health or chemical use issues a problem for someone in this group? Briefly Explain.

____

____

____.

hamm CLINIC

Client ID: ______________________ Date: _________________________

Client Name: ____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING __*0*__ + ________ + ________ + ________

=Total Score: _________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

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

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