The Priority Care Center
A Program of the Humboldt IPA

Section 1—Demographic Information

Primary Care Physician:	How were you referred:

Name (Last, First, M.I.):	A.K.A.:

Date of Birth: / /	Age:	Gender: Male Female Transgender Other

Mailing Address:

City:	State:	Zip Code:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

E-mail Address:	Do we have permission to contact you via e-mail? Yes No

Primary Spoken Language:	To which racial or ethnic group(s) do you *most* identify:
English	African-American (non-Hispanic)
Spanish	Asian/Pacific Islanders
Portuguese	Caucasian (non-Hispanic)
Other:	Latino or Hispanic
	Native American or Aleut
	Other:

Marital Status: Single Partnered Married Separated Divorced Widowed	Full name of spouse or significant other:

Employer Name:	Employer Address:	Occupation:

Employment Status (choose all that apply): Full-time Part-time Self-employed Not employed Retired Active Military	Driver's License Number:

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:

Address:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:

Address:	Subscriber's SSN:

Secondary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:

Address:	Subscriber's SSN:

Other Insurance:	Subscriber ID Number:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Group Number:	Group Name:

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:

Address:	Subscriber's SSN:

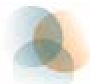
Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to for The Priority Care Center to obtain my prescription history.

Signature____ Date__________/__________/__________



Name________________________ DOB ____________

The Priority Care Center

A Program of the Humboldt IPA

Name: ____ DOB: _______________ Gender: ☐M ☐F

Primary Care Provider: ____

Preferred Pharmacy: ____________________________________Location: _____________________

CURRENT MEDICATIONS/SUPPLEMENTS (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

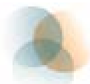
Past Medical History (Check all that apply)

☐ Acid Reflux/GERD	☐ Chronic Pain	☐ High Blood Pressure
☐ ADHD	☐ Depression	☐ High Cholesterol
☐ Alcoholism	☐ Diabetes	☐ Irritable Bowel
☐ Allergies	☐ Emphysema/Bronchitis/COPD	☐ Kidney Disease
☐ Anemia	☐ Epilepsy/Seizure Disorder	☐ Liver Disease
☐ Anxiety	☐ Glaucoma/Cataracts	☐Osteoporosis
☐ Arthritis	☐ Headaches	☐ Stroke
☐ Asthma	☐ Hearing Loss	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Heart Disease	☐ Other: ____________________
☐ Cancer		

Allergies

☐ No Known Allergies	☐ Medication Allergies	☐ Environmental/ Seasonal Allergies	☐ Latex Allergy

List Allergies	Reaction



Name________________________ DOB ____________

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Past Surgical History

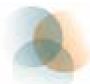
Date of Surgery	Type of Surgery

Family Medical History

Members	Status (Alive/Deceased)	Diabetes	High blood pressure	Heart Disease	Mental Illness	Cancer (Type)	High cholesterol	Unknown
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								
Children								

Social History

Tobacco Use: Current use: ☐Yes ☐No
Past Use: ☐Yes ☐No When did you quit? ____________________________
Type: ☐Cigarettes ☐Cigars ☐Chew ☐E-cigarette
Recreational Drug Use: ☐Yes ☐No
Type: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamine ☐Other______________________
Alcohol Use: ☐Daily ☐4-5 times per week ☐1-3 times per week ☐less than one time per week ☐none
Type: ☐Beer ☐Wine ☐Liquor
Marital Status: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
Living Situation: ☐Own ☐Rent ☐Homeless ☐Other ____
Children: ☐Yes ☐No if yes, do they live with you ☐Yes ☐No
Support Network: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other _________________
Diet/Exercise: Are you on a special diet? ☐Yes ☐No if yes, what type _______________________________
Do you Exercise? ☐Yes ☐No If yes, how often ☐Daily ☐3-5 days per week
☐1-2 days per week ☐less than once per week
What type ____



Name________________________ DOB ____________

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Do you have an Advance Directive in place?
☐Living Will ☐Durable Power of Attorney ☐Advanced Directive ☐POLST ☐None

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients			
Last Tetanus Booster	☐ Within past 10 years	☐ More than 10 years ago	☐ Unknown
Last Eye Exam (Dilated or Retinal)	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last Hearing Exam	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last Dental Exam	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last Foot Exam	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last colonoscopy/ sigmoidoscopy/Or stool test	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last DEXA Bone Scan	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last Pneumonia Vaccine	Date: __________		
Flu shot this season?	☐ Yes ☐ No		
Women Only			
Last Pap Smear	Date: __________	☐ Normal ☐ Abnormal	☐ Unknown
Last Mammogram	Date:	☐ Normal ☐ Abnormal	☐ Unknown

Concerns

Please indicate any concerns regarding your health in the space provided

____
____
____
____
____
____
____
____
____
____

v4;jrc3222016

NAME: ______________________________

Date: ______________________

PHQ-9	*Over the **last 2 weeks** how often have you been bothered by any of the following problems?*	*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*
	PHQ-9 total score =				

Would you like someone from our office to contact you before your appointment regarding any of the above?

____Yes _____No

Are you currently undergoing any treatment for depression?

☐ **Medications:** ______________________________

☐ **Counselor:** ______________________________

☐ **Other:** ______________________________

Client Name: ______________________ **DOB:** ________ **Date obtained:** ______________

(PROMIS) Patient Reported Outcomes Measurement Information System is a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

Global Health Assessment

Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).

Questions	Excellent (5)	Very Good (4)	Good (3)	Fair (2)	Poor (1)
Global 01: In General, would you say your health is					
Global 02: In general, would you say your quality of life is					
Global 03: In general, how would you rate your physical health?					
Global 04: In general, how would you rate your mental health, including your mood and your ability to think?					
Global 05: In general, how would you rate your satisfaction with your social activities and relationships?					
Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.					
	Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					
	None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08: How would you rate your fatigue on Average?					
Global 07: How would you rate your pain on average?	☐ 0	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9	☐ 10
To be completed by staff: Total Score (G03, 06, 07, 08) Total Score (G02, 04, 05, 10)					____________

ADULT DIABETES HISTORY

Name:

DOB:

MR#: HCL#:

Attach label or addressograph

Date of Diagnosis

Pharmacy Name	Pharmacy Phone

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Cohabitating

# in household	Relationship

Will significant others participate in program?
☐ No ☐ Yes ▶ Relationships: Names:

Race / Ethnicity (check all that apply)
☐ White ☐ Native American ☐ Black or African American ☐ Multi-race
☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander

What level of schooling have you completed?
☐ Elementary school ☐ High school diploma ☐ Some college ☐ College/University degree
☐ Technical/Vocational/Business ☐ Military training ☐ Graduate school ☐ Other: ______

Occupation
☐ Managerial/Professional ☐ Skilled labor ☐ Military ☐ Unemployed
☐ Technical/Sales/Clerical ☐ Other labor ☐ Student ☐ Other: ______
☐ Education/Teacher ☐ Homemaker ☐ Retiree

Is your job physically active or inactive?
☐ Active ☐ Inactive

Primary/Referring Physician	Phone

Physician's Address

Have you had diabetes education?
☐ No ☐ Yes ▶ Where? ______ Date: ______

Do you have specific educational needs?
☐ No ☐ Yes ▶ What kind? ______

Do you have any medication allergies?
☐ No ☐ Yes ▶ What kind? ______

Have you ever been diagnosed with any of the following conditions, or do you have a concern?

Diagnosed	Concern		Diagnosed	Concern		Diagnosed	Concern	
☐	☐	High blood pressure	☐	☐	Thyroid disease	☐	☐	Stomach or bowel problems
☐	☐	Heart disease	☐	☐	Eye or vision problems	☐	☐	Depression
☐	☐	Abnormal blood lipids (fats)	☐	☐	Kidney disease			
☐	☐	Circulation problems	☐	☐	Skin			
☐	☐	Numbness/pain (hands/legs/feet)	☐	☐	Dental or mouth problems			
☐	☐	Foot problems	☐	☐	Liver disease			

Family History of:
Diabetes ☐ No ☐ Yes
Thyroid disease ☐ No ☐ Yes
Heart disease ☐ No ☐ Yes

List past surgeries and/or hospitalizations with dates:
Surgery/Hospitalization: ______ Date: ______
Surgery/Hospitalization: ______ Date: ______
Surgery/Hospitalization: ______ Date: ______
Surgery/Hospitalization: ______ Date: ______

Date of last eye exam	Date of last dental exam	Date of last foot exam

If you are female:
Are you pregnant? ☐ No ☐ Yes
Are you considering pregnancy? ☐ No ☐ Yes
Are you currently using birth control? ☐ N/A ☐ No ☐ Yes Type of birth control: ______
Are your menstrual cycles regular? ☐ N/A ☐ No ☐ Yes If no, explain: ______

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NUTRITION AND LIFESTYLE HISTORY

What food-planning methods have you followed in the past? (check all that apply)

☐ Calorie counting ☐ Low carbohydrate ☐ Fat-gram counting ☐ No added sugar ☐ Other: ____________
☐ Carbohydrate counting ☐ Exchange lists ☐ Food pyramid / Healthy choices ☐ No method taught ____________

What method of diabetes food planning (if any) are you currently using?

How often do you follow a diabetes food plan?
☐ 0 ☐ 1–25% ☐ 26–50% ☐ 51–75% ☐ >75%

Typical Day Schedule: Please fill in the **times** of your meals and snacks, along with an example of the **type and amount** of food you might eat for your meals and snacks.

	TIME	TYPICAL MEALS - Example of 1 typical day
I get up at		
Breakfast		Breakfast:
Morning snack		Morning snack:
Midday meal		Midday meal:
Afternoon snack		Afternoon snack:
Evening meal		Evening meal:
Bedtime or bedtime snack		Bedtime or bedtime snack:
I go to bed at		

Do you exercise?
☐ No ☐ Yes ▶ What type(s)? ☐ Walking ☐ Biking ☐ Active job
☐ Swimming ☐ Sports ☐ Aerobic machine ☐ Other: ____________

How many times per week do you exercise?
☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ more than 6

For how many minutes per time?
☐ 0 ☐ 1–10 ☐ 11–15 ☐ 16–30 ☐ more than 30

Have you ever been advised by a physician to limit your exercise in any way?
☐ No ☐ Yes ▶ Explain: ____________

Outside work, how many minutes a day are you physically active?

Has your weight changed in the past year?
☐ No ☐ Yes ▶ How much? ________ ☐ Gain ☐ Loss

Do you drink alcohol?
☐ No ☐ Yes ▶ Type(s), amount, and times per week: ____________

Do you use tobacco?
☐ No ☐ Yes ▶ Type: ____________ Amount per day: ____________

Former tobacco user?
☐ No ☐ Yes ▶ Quit date? ____________

Do you use street drugs?
☐ No ☐ Yes

List all of your medications including over-the-counter medications and vitamin/mineral supplements:

____

____

____

ORAL DIABETES MEDICATIONS / NONINSULIN INJECTABLE

START DATE	NAME	DOSE	TIME OF DAY	SIDE EFFECTS?
				☐ No ☐ Yes ▶ Describe:
				☐ No ☐ Yes ▶ Describe:
				☐ No ☐ Yes ▶ Describe:

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INSULIN

Insulin Doses (pump users, see below): Please circle the types of insulin you are taking and write down your current insulin doses.

	BREAKFAST	MIDDAY MEAL	EVENING MEAL	BEDTIME	SNACKS
Regular Apidra® (glulisine) Humalog® (lispro) NovoLog® (aspart)					
NPH Lantus® (glargine) Levemir® (detemir)					
70/30 (with aspart) 70/30 (with Regular) 75/25 (with lispro) 50/50 (with lispro) 50/50 (with Regular)					

Pump Users: Please write down all of your bolus and basal rates and carbohydrates for the last 24 hours.

TIME	12 AM	1	2	3	4	5	6	7	8	9	10	11	12 PM	1	2	3	4	5	6	7	8	9	10	11	
Carbs																									Total Carbs
Bolus																									Total Bolus
Basal																									Total Basal

If you take insulin, please answer the following:

Are you using an insulin-to-carbohydrate ratio?
☐ No ☐ Yes ▶ What is the ratio? ________ Units of insulin per __________ grams of carbohydrate

Do you supplement with extra insulin when your blood glucose is high (sliding scale)?
☐ No ☐ Yes ▶ Fill in the scale you use in the table to the right.

Injection sites
☐ Stomach ☐ Arm ☐ Leg ☐ Buttocks

Where do you store unopened insulin?

Where do you store insulin currently in use?

Do you use an insulin pen?
☐ No ☐ Yes

Where do you dispose of needles/syringes/lancets?

Supplemental Scale (correction factor)

Blood Glucose	+ Insulin

BLOOD GLUCOSE MONITORING

Are you testing your blood glucose (sugar)?
☐ No ☐ Yes ▶ When? ______________________

What time(s) of the day do you test?

Do you know your last A1C?
☐ No ☐ Yes ▶ Result: ________ Date: ____________

Do you ever check for ketones?
☐ No ☐ Yes ▶ When? ______________________

What type of meter do you use?

Do you have a target blood glucose range?
☐ No ☐ Yes ▶ What is it? ________ mg/dL to ________ mg/dL

Do you have a target A1C?
☐ No ☐ Yes ▶ What is it? ______________________

Do you use foil-wrapped ketone strips?
☐ No ☐ Yes

HYPOGLYCEMIA

Do you experience low blood glucose (hypoglycemia)?
☐ No ☐ Yes ▶ What time of day does it occur? ______________________ Do you require assistance from others? ☐ No ☐ Yes

Do you have lows that you don't feel?
☐ No ☐ Yes

Do you carry food to treat lows?
☐ No ☐ Yes ▶ What? ______________________

Do you wear medical ID?
☐ No ☐ Yes

Do you have a glucagon emergency kit?
☐ No ☐ Yes ▶ Expiration date: ______________________

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LIFESTYLE AND BEHAVIORAL ASSESSMENT

Most Important Concerns

What do you feel are your most important concerns regarding your diabetes management?
What would you like to learn during your visits?
Did you require hospitalization at diagnosis? ☐ No ☐ Yes ▶ How long?

Check each of the items below that may concern you.

☐ 1. Do you have problems with sleeping (such as insomnia, sleep apnea, nightmares, or talking in your sleep)?

☐ 2. Do you have problems with eating or exercising (such as eating too little, overeating, or overexercising)?

☐ 3. Do you have problems with depression or noticeable mood changes (such as feeling sad, having mood swings, or experiencing increased irritability)?

☐ 4. Do you have problems with anxiety, nervousness, or stress (such as feeling worried all the time or overstressed)?

☐ 5. Do you have problems in social, school, or work environments (such as decreased productivity, avoidance, or withdrawal)?

☐ 6. Do you have problems with relationships with other people (such as friends, people at school, or people at work)?

☐ 7. Do you have problems within your family (such as conflict, marital conflict, or disciplining children)?

☐ 8. Do you have problems with certain kinds of inappropriate or undesirable behaviors (such as aggression, overactivity, repeating behaviors you do not want to repeat, or illegal behavior)?

☐ 9. Do you have problems with addictive behaviors (such as drug or alcohol abuse, gambling, or workaholic behavior)?

☐ 10. Do you have problems with sexual functioning (such as erectile dysfunction, vaginal dryness, or loss of desire)?

Concerns Specific to Diabetes

☐ 11. Do you have problems coping with diabetes (such as not being able to test your blood glucose or eat when you need to)?

☐ 12. Do you have problems within your family (such as not setting limits with family members regarding diabetes care)?

☐ 13. Do you have problems at work (such as getting time for diabetes care or experiencing discrimination because of diabetes)?

☐ 14. Do you have problems with relationships with other people (such as eating or testing in front of others)?

☐ 15. Have you ever been involved in therapy with a psychologist, counselor, or social worker?

☐ No ☐ Yes ▶For what? ______________________

When? ______________________

With whom? ______________________

What was helpful? ______________________

What was not helpful? ______________________

Who completed this form?	Relationship to Patient
Signature	

FOR HEALTH PROFESSIONAL USE

☐ Referral made and accepted

☐ Referral made and refused

☐ Referral pending

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Insulin

Basics

Knowledge Test

Name: ____ Date: __________________

Circle one: Session 1 Session 2 Session 3 Session 4

Directions: Read each question and decide which choice *best* completes the statement or answers the question. Indicate your answer by circling the appropriate letter.

1. Type 1 diabetes is caused by:
   a. Destruction of insulin producing cells
   b. Eating too many sweets
   c. Insulin deficiency and insulin resistance
   d. I don't know

2. Hemoglobin A1c (HbA1c) is a blood test that measures an average blood glucose level for the past:
   a. Day
   b. 2-3 months
   c. Week
   d. I don't know

3. Insulin causes blood glucose to:
   a. Increase
   b. Decrease
   c. Stay the same
   d. I don't know

4. A possible side effect of insulin is:
   a. High blood glucose levels
   b. Low blood glucose levels
   c. There are no side effects
   d. I don't know

5. Lispro (Humalog®) insulin is a rapid-acting insulin taken at the time of a meal or snack. It works effectively over what length of time?
   a. 2-3 hours
   b. 4-6 hours
   c. 68 hours
   d. I don't know

6. Hypoglycemia (a low blood glucose level) can be caused by:
   a. Missing or delaying meals
   b. Not taking enough insulin
   c. Eating too much food
   d. I don't know

7. Which of the following should NOT be used to treat hypoglycemia?
   a. 1 cup diet pop
   b. ½ cup orange juice
   c. 1 cup skim milk
   d. I don't know

Questions from the International Diabetes Center of Park Nicollet

<u>Insulin</u>

Basics

Knowledge Test

8. Drinking alcohol without eating can:
   a. Raise blood glucose levels
   b. Lower blood glucose levels
   c. Does not affect blood glucose levels
   d. I don't know

9. You should check for urine ketones when:
   a. Your blood glucose levels are low
   b. Your blood glucose levels are greater than 250 mg/dL, or you are sick
   c. You missed a meal
   d. I don't know

10. People with diabetes are at a higher risk for which of the following:
    a. High blood cholesterol and high blood pressure
    b. Asthma
    c. Bladder problems
    d. I don't know

11. Exercise is important in managing type 2 diabetes because it:
    a. Helps the body use insulin better and assists in weight control
    b. Increases blood glucose levels
    c. Increases the risk of heart and blood vessel disease
    d. I don't know

12. Food eaten by a person with diabetes to treat hypoglycemia should be:
    a. Subtracted from the next meal
    b. Subtracted from the evening meal
    c. Taken in addition to the total food allowance
    d. I don't know

13. Living well with diabetes involves:
    a. Always maintaining normal blood glucose levels
    b. Balancing good diabetes control with an active, full life
    c. Living your life around diabetes
    d. I don't know

14. Setting goals may help you make some important changes in your life. Which of the following is an example of a reasonable and measurable goal?
    a. I will be consistent with my carbohydrate intake at dinnertime
    b. I will exercise 2 hours every day of the week
    c. I will lose 5 pounds in the next month
    d. I don't know

Questions from the International Diabetes Center of Park Nicollet