Humboldt IPA

Priority Care Program

A GUIDE FOR YOUR HEALTH, WELLNESS AND SAFETY

AFTER HOURS CARE – holidays, weekends, nights

1. IF YOU ARE HAVING AN EMERGENCY, CALL 911 IMMEDIATELY.
2. Our normal business hours are Monday through Friday, 8 am to 5 pm. WE CLOSE FOR LUNCH FROM 12:30-1:30 daily.

Please bring your medication bottles with you to your visits.

HONESTY IS THE BEST POLICY

We promise to be honest with you about your health and wellness. In turn we ask that you are honest with us, particularly about your medical history and about your intentions to follow through with the plans we develop together to achieve and maintain your best possible health and wellness.

TEAMWORK

We at the Priority Care Center (PCC) work together and we consider you to be part of our team. We appreciate any feedback you have for us. When you have a question or concern, you may be hearing back from any one of the PCC team members who has the expertise to assist you. Our team members include professionals from these programs:

- Primary Care/Care Transitions
- Care Coordination
- Wellness Coaching
- Diabetic Education
- Mental and Behavioral Health

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The Priority Care Center
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Section 1—Demographic Information

Primary Care Physician:	Pharmacy: Location:	
Name (Last, First, M.I.):		Nickname?:
Date of Birth: / /	Age:	Preferred gender: Male Female Transgender Other
Mailing Address:		
City:	State:	Zip Code:
Home Phone: ☐ Preferred ( )	Work Phone: ☐ Preferred ( ) X:_____	Cell Phone: ☐ Preferred ( )
E-mail Address: Employer: SSN:		**Do you have an Advance Directive in place? (Circle)** Advanced Directive POLST None

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

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:

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:

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, 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 The Priority Care Center to obtain my prescription history.

☐ I give consent to contact me via Priority Care Center's secure patient portal.

Signature_____ Date_____/_____/_____

Name_____ Date: _____ DOB _____

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Current Medications/Supplements/Over the Counter
☐ Check this box if you brought your medication bottles with you

Medication	Strength	How are you taking
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

Medical History (Check all that apply)

Condition	Year diagnosed	Condition	Year diagnosed	Condition	Year diagnosed
□ Acid Reflux/GERD □ ADHD □ Alcoholism □ Allergies □ Anemia □ Anxiety □ Arthritis □ Asthma □ Bleeding Disorder □ Cancer		□ Chronic Pain □ Depression □ Diabetes: Type I or Type II □ Emphysema/Bronchitis/COPD □ Epilepsy/Seizure Disorder □ Glaucoma/Cataracts □ Headaches □ Hearing Loss R L □ Heart Disease □ Hepatitis		□ High Blood Pressure □ High Cholesterol □ Irritable Bowel □ Kidney Disease □ Liver Disease □ Osteoporosis □ Stroke □ Thyroid Disease □ Other: _____	

Allergies

□ No Known Allergies	□ Medication Allergies	□ Environmental/ Seasonal Allergies	□ Latex Allergy
List Allergies		**Reaction**	

Social History

Tobacco Use: Current use: ☐Yes ☐No
Marijuana Use: ☐Yes ☐No
Recreational Drug Use: ☐Yes ☐No
Alcohol Use: ☐Yes ☐No

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).

Last Eye Exam _____
Last Dental Exam _____
Last Foot Exam _____

ADULT DIABETES HISTORY

Name: Date: Date of Birth: / /

General Information

What do you feel are your most important concerns regarding your diabetes management?

What would you like to learn during your visits?

Year of Diagnosis: _____Type of Diabetes□:PreDiabetic□Type1□Type2□Gestational □Other

Was hospitalization required at diagnosis? □ No □ Yes

Have you had previous diabetes education? □ No □ Yes
Where? Date:

What level of schooling have you completed?
□Elementary School □Military Training □ Advanced Degree
□High School diploma □Some College □Other:_____
□Technical, Vocational, Business □College or University diploma _____

Occupation:

If you are female, please answer the following:

Are you pregnant? □No □ Yes	Are you considering pregnancy? □ N/A □ No □Yes

Are you currently using birth control? □N/A □No □Yes >Type of birth control:

Are your menstrual cycles regular? □ No □Yes
If no, please explain:

Nutrition

What food-planning methods are you currently following or have you followed in the past?
(check all that apply) □ No method taught/None

Current	Past		Current	Past	
□	□	Calorie counting	□	□	My Plate method
□	□	Low carbohydrate	□	□	Carbohydrate counting
□	□	Fat-gram counting	□	□	Exchange lists
□	□	No added sugar	□	□	Other:

How often do you follow the food planning method you are currently using?
□0 □ 1-25% □ 26-50% □ 51-75% □ >75%

How many meals per week do you eat away from home?

How many meals do you eat in a typical day?

Has your weight changed in the past year? □ No □ Yes
How much? □ Gain □ Loss

ADULT DIABETES HISTORY

Name: Date: Date of Birth: / /

Typical Day Schedule:

Time	What you typically eat and drink, and how much
	I wake up/get up
	Morning meal:
	Morning snack:
	Midday meal:
	Afternoon snack
	Evening meal
	Evening/bedtime snack
	I go to bed

Physical Activity

Have you ever been advised by a physician to limit your exercise in any way? □ No □Yes If yes explain:
Are you physically active? □No □Yes Check all that apply: □ walk □ jog □bike □aerobic machine □swim □sports □my job □other
How many days per week? □ 1 □2 □3 □4 □5 □6 □7 □>7
How long (in minutes)? □1-10 □11-15 □16-30 □>30

Blood Glucose Monitoring

When was your last A1c?_____ What was it?_____	Do you have a Continuous Glucose monitor (CGM)? □ No □ Yes
Are you testing your blood glucose (sugar)? □ No □ Yes	What type of meter do you use?
What time(s) of the day do you test? □Fasting □Before meals □After meals □Bedtime	Do you have a target blood glucose range? □ No □Yes Fasting _____ Before meals _____ After Meals _____ Bedtime _____
Do you ever check for ketones? □ No □ Yes >When?	

Hypoglycemia

Do you experience low blood sugars (hypoglycemia)? □ No □Yes What time/times of day does this 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:

ADULT DIABETES HISTORY

Name: Date: Date of Birth: / /

CONCERNS SPECIFIC TO DIABETES (check all that apply)

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

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

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

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

□ Have you ever been involved in therapy with a psychologist, counselor, or social worker?
□ No □ Yes

INSULIN
If you take insulin, please answer the following:

Are you using a correction factor? □ No □ Yes (see below) One unit of insulin lowers blood sugar by _____mg/dl Your target blood sugar:	Supplemental Sliding Scale	
	Blood Glucose	**+ Insulin**
Do you supplement with extra insulin when your blood glucose is high using a sliding scale? □ No □ Yes>Fill in the scale you use in the table to the right.		
Are you using an insulin-to-carbohydrate ratio? □ No □ Yes _____ units of insulin per _____ grams of carbohydrate		
How do you adjust for exercise?		
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?		

ADULT DIABETES HISTORY

Name: Date: Date of Birth: / /

Insulin Doses: (pump users, see below): Please circle the types of insulin you are taking and write down your current insulin doses. If using an insulin to carb ratio and/or correction factor list your average insulin dose for the times below. Listing a range is fine (3-5 units, 15-20 units).

	BREAKFAST	MIDDAY MEAL	EVENING	BEDTIME	SNACKS
Regular Apidra® (glulisine) Humalong® (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.
When did you start on a pump? Brand/model of pump

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:

NAME: _____DOB: _____

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:** _____