LOGAN HEALTH

Cut Bank

Rural Health Clinic

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Patient Name: _____ Birthdate: __/__/_____

Mailing Address: _____ City/State/Zip: _____

Physical Address: _____ City/State/Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Email Address: _____

Gender: M F Marital Status: Single Married Separated Divorced Widowed

Current Tobacco user: Yes No Quit

Patient SSN: _____ Race: Caucasian Native American African America Other

Allergies to Medications: _____

Employer Name: _____

Occupation: _____

Emergency Contacts (Someone outside of household)

1. Name: _____ Relation to Patient: _____
   Phone number: _____
2. Name: _____ Relation to Patient: _____
   Phone number: _____
3. Name: _____ Relation to Patient: _____
   Phone number: _____

Person responsible for payment

Name: _____ Relation to patient: _____
Guarantor SSN: _____ Birthdate: _____ Gender: M F

Phone number: Home: _____ Cell: _____

Mailing Address: _____ City/State/Zip: _____

Physical Address: _____ City/State/Zip: _____

Employer Name: _____ Phone number: _____

LOGAN HEALTH
Cut Bank

Patient Name:_____DOB_____Date_____Sex: M / F Race_____

Please tell us why you are here today_____

Please indicate onset date of any conditions you have had:

GENERAL
_____Serious Infections (e.g. pneumonia)_____
_____Diabetes Mellitus
_____Rheumatic Fever
_____HIV Infection
____Cancer (where?)_____

CVS
_____High Blood Pressure
_____Congestive Heart Failure
_____Heart Murmur
_____Heart Valve Disease
_____Angina
_____Heat Attack
_____High Cholesterol
_____Abnormal Heart Rhythm
_____Blood Clots in Veins
_____Blocked Arteries in Neck
_____Blocked Arteries in Legs

HEENT
_____Glaucoma
_____Allergies "hay fever"
_____Frequent Ear Infections

RESPIRATORY
_____Asthma
_____Emphysema
_____Blood Clots in Lungs
_____Sleep Apnea

MUSCULOSKELETAL/EXTREMITIES
_____Osteoporosis
_____Rheumatoid Arthritis
_____Degenerative Joint Disease
_____Fibromyalgia
_____Neck Pain (herniated disc)
_____Back pain (herniated disc)

LYMPHATIC/HEMATOLOGIC
_____Thyroid Goiter
_____Over Active Thyroid
_____Under Active Thyroid
_____Transfusion
_____Anemia

GI/GU
_____Stomach Ulcers
_____Ulcerative Colitis
_____Crohns Disease
_____Bleeding from Intestines
_____Diverticulitis
_____Colon Polyps
_____Irritable Bowel Disease
_____Hepatitis
_____Cirrhosis of the Liver
_____Liver Failure
_____Pancreatitis
_____Gallstones

_____Kidney Stones
_____Kidney Failure
_____Prostate Disease
_____Endometriosis
_____Sex Transmitted Infection

SKIN/BREAST
_____Acne
_____Eczema
_____Psoriasis
_____Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
_____Chronic Vertigo
_____Peripheral Nerve Disease
_____Migraine Headaches
_____Stroke
_____Multiple Sclerosis
_____Depression
____ Anxiety
_____Alcoholism
_____Drug Addiction

Comments:

Please indicate the year of any surgeries you have had:

_____Angioplasty
_____Carotid Artery Surgery
_____Other Vascular Surgery
_____Coronary Bypass Surgery
_____Chest/Lung Surgery
_____Tonsillectomy
_____Neurosurgery

_____Trauma Related Surgery
_____Back or Neck Surgery
_____Hip Surgery
_____Knee Surgery
_____Carpal Tunnel Surgery
_____Sinus Surgery
_____Ear Surgery

_____Stomach Surgery
_____Inguinal Hernia
_____Colonoscopy
_____Gallbladder
_____Appendectomy
_____Prostate Surgery
_____Bladder Surgery

_____Tubal Ligation
_____C-Section
_____Hysterectomy
_____Ovary Removed
_____Breast Surgery
_____Thyroid Surgery
_____Other_____

Please indicate the year of any preventative tests or services you have had:

_____Stress Test
_____Echocardiogram
_____Chest X-Ray
_____EKG
_____Bone Density Test

_____Flu Vaccine
_____Pneumonia Vaccine
_____Tetanus Vaccine
_____Hepatitis Vaccine
_____Prevnar

_____Prostate Cancer Blood Test
_____Rectal Exam
_____Colon Cancer Stool Test
_____Flexible Sigmoidoscopy
_____Barium Enema

_____Mammogram/Breast Exam
_____Pap Smear
_____Date of Last Physical Exam
_____Eye Exam
_____Hearing Exam
_____Other_____

*****PLEASE CONTINUE ON OTHER SIDE*****

Please list any allergies or intolerance to any drugs or other substances._____
_____
_____

Please list current medications, dosages, and how many times per day you take them.

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY MEDICAL HISTORY

Please indicate any major illness in you family members. ***M-Mother; F-Father; MGM-maternal grandmother; MGF-maternal grandfather; PGM-maternal grandmother; PMF-paternal grandfather ; S-sibling***

_____Tuberculosis **_____Emphysema** **_____Heart Disease** **_____High Blood Pressure** **_____Osteoporosis** **_____Anxiety/Depression/Mental Illness type** **Comments:**	**_____Diabetes Mellitus** **_____Thyroid Disease** **_____Amnesia** **_____Hemophilia** **_____**	**_____Kidney Disease** **_____Epilepsy** **_____Neurological Disorder** **_____Liver Disease** **_____**	**_____Breast Cancer** **_____Ovarian Cancer** **_____Colon Cancer** **_____Prostate Cancer** **_____**

PERSONAL INFORMATION

Occupation:_____
Please write in or circle the information that applies to you:

Marital Status	Living Status	Diet	Exercising	Alternative Medicine
single	alone	none	none	holistic
married	with spouse	low fat	walking	chiropractic
divorced	with parents	low chol	aerobics	homeopathy
widowed	assisted Living	low carb	weightlifting	acupuncture
separated	nursing Home	vegetarian	____days/wk	herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past/ active	never / past/ active	Never / past/ active	never / past/ active
cigarette / cigar / e-cig	liquor / wine / beer	cocaine / marijuana	coffee / tea / soda
snuff / dip / chewing	_____drinks per	heroin / amphetamine	_____cups per day
Start_____stop_____	day / week / month	barbiturate / LSD / PCP	
packs per day_____	AA / Alcohol Rehab	IV drug Abuse / Drug Rehab	

THANK YOU
FOR TAKING THE TIME TO PARTICIPATE IN YOUR HEALTH CARE!

LOGAN HEALTH

Rural Health Clinic – Cut Bank
226 Ninth Avenue Southeast | Cut Bank, MT 59427 | (406) 873-5507

MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Logan Health Cut Bank Rural Health Clinic (RHC) When you schedule an appointment with Logan Health Cut Bank, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than four (4) hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective December 1, 2021, any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 4 hours' notice will be considered a No Show. The missed appointment will be entered into the patients' electronic medical record (EMR) and the patient will receive a missed appointment letter via U.S. postal service.

- Any patient who fails to show or cancels/reschedules an appointment without a 4 hour notice a second time will receive a second missed appointment letter via U.S. postal service and the missed appointment will be entered into the patient's EMR.

- If a third No Show or cancellation/reschedule with no 4 hour notice should occur within one calendar year (12 months) the patient may be dismissed from Logan Health Cut Bank RHC. The patient will receive a certified letter via U.S. postal service with notification of dismissal. Patient dismissals are determined by all RHC providers and clinic manager, no exceptions, in accordance with the policy

- Arriving more than 15 minutes late for a scheduled appointment will result in the clinic manager determining the patient has missed (no-showed) the scheduled appointment. Late arrival for any appointment scheduled will not be seen by the provider due to limited length of time and will be considered a no-show.

- As a healthcare facility we understand the importance of Behavioral Health (BH). A patient's dismissal from primary care may not include services from BH. BH service may still be utilized by the dismissed patient if deemed necessary by the BH provider.

- Exceptions to the policy will be handled on a case by case basis by the clinic manager and clinical medical director. We understand there may be times when unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Clinic Manager. You may contact Logan Health Cut Bank RHC 24 hours a day, seven (7) days a week at the number below. Should it be after regular business hours Monday through Friday, a weekend, or holiday, please leave a message.

Logan Health Cut Bank Rural Health Clinic: (406) 873-5507

I have read and understand the Logan Health Cut Bank Rural Health Clinic Medical Appointment Cancellation / No Show Policy and agree to its terms.

Patient Printed Name: _____ Patient DOB: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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
	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____ x 0 =	_____
Several days	(#) _____ x 1 =	_____
More than half the days	(#) _____ x 2 =	_____
Nearly every day	(#) _____ x 3 =	_____

Total score: **_____**

Interpreting PHQ-9 Scores

Minimal depression	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Actions Based on PH9 Score

Score	Action
< 4	The score suggests the patient may not need depression treatment
> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/