NEW PATIENT PAPERWORK

Please Print:

Method of Payment: Cash ___ Credit Card ___ Check ___

Male: ___ Female: ___ Student: Yes___ or No___ Full Time___ or Part Time___

Patient Full Name: _____ Age: _____
Date of Birth: Month _____ Date _____ Year _____ SSN: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: ( ) _____-_____ Married__ Single __ Widowed __ Divorced __

Referred By: _____ Previous Physician: _____

In case of an emergency, list two relatives or friends we can contact not living with you:
Name: _____ Relation: _____ Phone: ( ) _____-_____
Name: _____ Relation: _____ Phone: ( ) _____-_____

Patient Occupation: _____ Patient Cell Number: ( ) _____-_____

Patient Employer: _____ Phone: ( ) _____-_____
Business Address: _____
City: _____ State: _____ Zip Code: _____

Patient E-mail:_____

Assignment of Benefits:
I HEREBY ASSIGN ALL MEDICAL AND / OR HOSPITAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS, TO DANIEL JUAREZ, M.D., P.A.. **This Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.**

Signed: _____ Date: _____
Please present your insurance card(s) to the receptionist.

Daniel Juarez, M.D., P.A.
Internal Medicine

Adult Questionnaire

In order to provide the best medical care possible, your doctor must know not only what your present symptoms are but also what diseases you have been exposed to and what problems you may be at risk for developing. For this reason you are requested to carefully fill out this screening health questionnaire. This along with the history of examination your doctor obtains when you visit him will provide a complete medical evaluation of your current and potential medical problems.

Date: _____

Patient Name: _____ Age: _____ Sex: _____ Race: _____

Next of Kin: _____Phone ( ) _____-_____

Insurance Name: _____

Please complete the following questions:

In a few words please state why you are coming to see the doctor: _____

_____

_____.

What are your medical problems? _____

_____

_____.

INJURIES: Please list serious injuries and broken bones with approximate dates

_____

_____

_____.

OPERATIONS: Please list the operations you have had. Do not omit minor operations such as tonsils, vasectomy, D&C, etc.

Operation	Date	Hospital	Surgeon

HOSPITALIZATIONS: Please list your hospitalizations other than those described above

Date	Illness	Hospital	Physician

MEDICATIONS: Please list all medications you take. Do not forget birth control pills, sleeping pills, vitamins, or nasal preparations

_____

_____

_____

_____

_____

_____

ALLERGIES: Please list all the medications you are allergic to

Medication	**Type of reaction**	**Date of reaction**
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS: Please indicate your average daily consumption of the following and how long you have used them

Whiskey _____ **Coffee** _____
Beer_____ **Tea** _____
Wine _____ **Cigarettes** _____
Marijuana_____ **Pipes & Cigars** _____

IMMUNIZATIONS: Please indicate the last year you received each of the following immunizations

Tetanus_____ **Influenza (Flu)** _____ **Hepatitis B** _____ **Pneumonia**_____

FAMILY HISTORY: Age(s) if Alive Age(s) at Death Medical Problem or Cause of Death

Spouse _____
Father _____
Mother _____
Brother's _____
Sister's _____
Child _____
Paternal Grandmother _____
Paternal Grandfather _____
Maternal Grandmother _____
Maternal Grandfather _____

Who in your family has had the following diseases? Please include yourself

Alcoholism _____ Kidney Disease/Stone _____
Arthritis _____ Migraine Headaches _____
Bleeding Disorder_____ Nervous Breakdown/Depression _____
Cancer _____ Osteoporosis _____
Dementia _____ Stroke _____
Diabetes _____ Tuberculosis _____
Heart Disease _____ Other_____
Hypertension (High Blood Pressure) _____ _____

INFECTIONS: Please give the approximate age when you had each of the following

Tuberculosis_____ Rheumatic_____ Fever Hepatitis_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE BEEN TROUBLED WITH:

GENERAL: Weight loss (How much? _____ and over what period of time? _____)

Poor Appetite Weakness Night Sweats

SKIN: Itching Burning Rash Hives Acne Psoriasis

Melanoma Change in mole

HEAD: Headache more than once a week Dizziness/Lightheaded

EYES: Pain Double Vision Blurred Vision Redness Tearing

EARS: Earache Drainage or discharge from ear Motion Sickness

Ringing or other noises Difficulty hearing (How long? _____)

NOSE: Do you frequently have a stuffy nose when you do not have a cold? _____

Frequent Nose Bleeds Post Nasal Drip Trouble Smelling Allergies

MOUTH: Dentures Dry Mouth Sore or burning tongue Problems with teeth

Changes in taste Hoarseness Frequent sore Throats

NECK: Frequent stiffness Goiter Pain Frequent swollen glands

BREASTS: Tenderness Nipple Discharge Lumps/Masses Breast Biopsy

RESPIRATORY: Cough Coughing up blood or blood streaked phlegm Pneumonia

Bronchitis Wheezing/Asthma Phlegm production in the morning Emphysema

Coughing after eating Chest colds more often than once a month Trouble swallowing

CARDIOVASCULAR: Palpitations Thumping in the chest Irregular heartbeat

Fainting Spells Swelling ankles Cramps in your legs on walking Cramps in leg at night

Getting up at night to urinate Shortness of breath Night cough Chest pain or discomfort/angina

High blood pressure Congestive heart failure Heart murmur/abnormal heart valve

GASTROINTESTINAL: Pain Heartburn Intolerance to any foods Vomiting Diarrhea

Constipation Recent change in bowel habits Jaundice Clay colored stools

Urine the color of coca cola Black or tarry stool Floating stools Blood in the stool or toilet paper

Vomiting of blood or coffee ground like material Rectal itching Ulcerative colitis/ Crohn's

Milk intolerance Mucus in stools Pancreatitis Diverticulitis Hemorrhoids (piles)

Esophagitis/Reflux Gallbladder trouble Ulcers Liver Disease Cirrhosis

Hiatus hernia Colon Polyps / Colon Cancer or family history

GENITOURNARY: Kidney stones Blood in urine Incontinence/loosing urine

Bed Wetting Urgency Burning Straining on urination

How many times do you get up at night to urinate? _____

WHEN DID YOU LAST HAVE ANY OF THE FOLLOWING?

Chest X-Ray_____ Electrocardiogram _____

Barium Enema_____Colonoscopy _____

Upper GI Series_____Mammogram_____

Transfusion History_____ Lab Work _____

MEN: Discharge from penis Prostatitis Pain Swelling

WOMEN: Discharge from vagina Itching Bleeding between periods Cramps

Date of last pelvic exam_____ Date of last PAP smear _____

Date of last menstrual period _____ Duration of flow? _____

Menstrual period: Age at onset_____ Days between periods_____

Do you use birth control? _____ What method? _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU MIGHT HAVE BEEN TROUBLED WITH:

PREGNANCIES: How many pregnancies? _____ Live births? _____ Weight of largest baby? ____

During pregnancy did you have the following: Diabetes Seizures High blood pressure Swelling of ankles Albumin or protein in urine

MUSCULOSKELETAL: Arthritis Joint stiffness in the morning Bone pain Muscle pain Swollen joints Low back pain Varicose veins Phlebitis Cold or blue fingers Rheumatoid Arthritis Lupus

NEUROLOGICAL: Seizures Epilepsy Stroke Paralysis Muscle weakness Tremors Muscle wasting Numbness Neuritis

GLANDS: Goiter Thyroid Disease Change in texture of hair Diabetes

BLOOD: Anemia Easy bruise ability Bleeding disorder

PSYCHIATRIC: Insomnia Hopeless feeling Feeling blue Crying Shyness Thoughts of suicide Difficulty relaxing Excess worrying Sexual problems

Have you ever been hospitalized for emotional reasons? _____

Have you ever been on medication for emotional reasons? _____

Reason/Diagnosis _____

Have you ever been to see a psychiatrist or Social Worker? _____

Daniel Juarez, M.D., P.A.
Internal Medicine
Acknowledgement Form

I understand that as part of my healthcare, Daniel Juarez, M.D., P.A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that his information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party-payer can verify that services billed were actually provided*
- *And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment. I understand that Daniel Juarez, M.D., P.A. reserves the right to change its practices and to make the new provisions effective for all protected health information maintained by Daniel Juarez, M.D., P.A.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Daniel Juarez, M.D., P.A. is not required to agree to the restrictions requested. Daniel Juarez, M.D., P.A. will not use or disclose your health information without your authorization, except as described in the Notice of Privacy Practices.

Daniel Juarez, M.D., P.A. records may contain information created by an entity other than Daniel Juarez, M.D. PA Daniel Juarez, M.D., P.A. is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility or lack thereof such incorporated records). Patient expressly requests release of all records maintained by Daniel Juarez, M.D., P.A. concerning patient, including incorporated records. Patient acknowledges that Daniel Juarez, M.D., P.A. has no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

_____ _____

Signature of Patient or Legal Representative Date Signed by Patient or Legal Representative

_____ _____

Signature of Witness Date Signed by Witness

Daniel Juarez, M.D., P.A. was unable to obtain acknowledgment/consent because:

Emergency Patient Non-Responsive Patient Confused/Disoriented Patient Sedated

Patient Refused- Reason _____

Patient Name: _____ Date: _____

Expanded Clinical Assessment

Please answer the following questions and check all that apply (✔).

	Yes	No
1. Do you have heart Failure?		
a. Do you experience Shortness of breath, for instance walking short distances or lying in a flat position?		
b. Have you been hospitalized for your heart since your last visit?		
c. Have you had your heart failure medications changed recently?		
d. Have you been tired or lightheaded since your last visit?		
e. Have you noticed a sudden increase in your weight for instance 3 of more pounds in one week?		
2. Have you had shortness of breath since your last doctor visit?		
a. Do you have a history of Heart related problems?		
b. Do you have a history of Lung related problems?		
3. Have you been told you have high blood pressure?		
a. Are you taking medication?		
b. Are you taking 2 or more pills for your high blood pressure?		
c. Are you taking a water pill (diuretic)?		
d. If you have recently monitored your blood pressure, please provide measurement below: ✔Blood Pressure _____/_____		

Daniel Juarez, M.D., PA
Internal Medicine
1303 McCullough Ave
San Antonio, TX 78212
Ph: 210-220-3737 Fax: 210-220-3747

EFECTIVE 01/01/2020

NOTICE OF LATE CANCELLATION/NO SHOW POLICY

Due to high volume of patients in our office, it is necessary to enforce our cancellation/no show policy. As a patient of our clinic, it is your responsibility to keep scheduled appointments.

All patients are required to give a 24-hour notice of appointment cancellations; this gives our office enough time to contact another patient waiting for an appointment.

If a 24-hour cancellation is not given then the patient will be billed a $50.00 cancellation fee. This fee will be the patient's responsibility and will not be billed to any insurance company.

We also will be charging the cancellation fee to all patients who No Show to their scheduled appointment, without prior notification.

By signing below I hereby acknowledge and understand the office policies listed above.

_____ _____

Patient/Guardian Signature Date:

_____ _____

Witness: Date:

Daniel Juarez, M.D., PA
Internal Medicine
1303 McCullough Ave
San Antonio, TX 78212
Ph: 210-220-3737 Fax: 210-220-3747

MID LEVEL PROVIDER JOB DESCRIPTION

Date: _____

To Whom It May Concern:

This office employs mid-level providers (Physicians Assistants and/or Nurse Providers). The Physician assistant shall provide, within the education, training, and experience of the physician assistant, medical services that are delegated by the supervising physician. Their training allows them to evaluate patients for both acute and chronic illnesses and treat them accordingly. As a patient in this practice there will be times that you will be required to see the PA or NP, their patient goals are:

1. Obtaining patient histories and performing physical examinations.
2. Ordering and/or performing diagnostic and therapeutic procedures.
3. Formulating a working diagnosis.
4. Developing and implementing a treatment plan.
5. Monitoring the effectiveness of therapeutic interventions.
6. Offering counseling and education to meet patient needs.

Patient/Guardian Signature: _____

Employee Signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY

Daniel Juarez, M.D., P.A. uses health information about you for treatment, to obtain payment for treatment, for Administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of **Daniel Juarez, M.D., P.A.**

How Daniel Juarez, M.D., P.A. May use or Disclose Your Health Information

For Treatment:
Daniel Juarez, M.D., P.A. may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for healthcare providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. **Daniel Juarez, M.D., P.A.** may use your health information when referring you to other health care professionals and facilities.

For Payment:
Daniel Juarez, M.D., P.A. may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. **Daniel Juarez, M.D., P.A.** may use your information to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Health Care Operations:
Daniel Juarez, M.D., P.A. may use and disclose health information about you for operational purposes For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services ; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law:
Daniel Juarez, M.D., P.A. may use and disclose information about you as required by law. For example, **Daniel Juarez, M.D., P.A.** may disclose information for the following purposes**:**

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls:
Daniel Juarez, M.D., P.A. may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification:
Daniel Juarez, M.D., P.A. may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location, and general condition.

Communication with Family:
Daniel Juarez, M.D., P.A.'s health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.

2. You are entitled to see your medical records.

3. You are entitled to receive a copy of your medical records. (Forms are available upon request). As per allowance by HIPPA there may be a charge for making copies of any requested records.

4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request).

5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request). If the doctor disagrees, he shall supply you with written notification of such disagreement.

6. The doctor has a right a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.

7. You have the right to specify how access to your health is restricted and from whom.

8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications you shall be forwarded.

9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy

Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of healthcare services and administration of such services, shall be part of a "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information. As are we.

10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.

11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.

12. This Practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only the information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf). And so as to maintain the intent of HIPAA in establishing that standard.

13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.

14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at,

Toll Free: 1-877-696-6775 or E-mail: www.hhs/gov/ocr

PATIENT'S AFFIRMATION OF RECEIPT
OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

_____ _____

Patient/Guardian Signature **Date**

Daniel Juarez, M.D., PA
Internal Medicine
1303 McCullough Ave
San Antonio, TX 78212
Ph: 210-220-3737 Fax: 210-220-3747

I understand the HIPAA Laws and Regulations and I give Daniel Juarez, M.D., P.A. Authorization to release any medical information on my well-being and medications to the following: (e.g. spouse, son, daughter, caregivers, etc…)

Please list Name and Phone Number of individuals you authorize Daniel Juarez M.D., P.A. to release/communicate with regarding your medical information

NAME:	PHONE NUMBER:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Print Name Date of Birth

_____ _____

Patient/Guardian Signature Date

Daniel Juarez, M.D., PA
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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data is maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM's) are third party administrators of prescription drug claims whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give **Daniel Juarez, M.D., P.A.** to access my pharmacy benefits data electronically through Sure Scripts.

This consent will enable **Daniel Juarez, M.D., P.A**. to:

- ***Determine the pharmacy benefits and drug co-pays for a patient's health plan.***
- ***Check whether a prescribed medication is covered (in formulary) under a patient's plan.***
- ***Display therapeutic alternatives with preference rank (if available) within a drug class for non formulary medications.***
- ***Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.***
- ***Download a historic list of all medications prescribed for a patient by any provider.***

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using Sure Scripts.

_____ _____

Patient/Guardian Signature Date:

_____ _____

Witness: Date:

MACRA and Annual Wellness Exam Questionnaire

As part of the MACRA legislation, the government requires that we ask the questions below; this is to help with your quality of care standards. Please speak to your provider if you have any questions.

Today's Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____ E-mail: _____

Gender: _____ Ethnicity: _____ Race: _____

When was your last annual complete physical? _____

Circle YES or NO for the following questions.

1. Have you had your flu vaccination?	YES	NO	What Date: _____
2. Have you had a pneumonia vaccination?	YES	NO	What Date: _____
3. Have you had a colonoscopy?	YES	NO	What Date: _____
4. Do you currently use tobacco?	YES	NO	
5. Have you ever used Tobacco?	YES	NO	
6. Do you take an aspirin every day?	YES	NO	
7. Do you have high blood pressure?	YES	NO	
8. When was your last dental exam? _____ Doctor: _____			
9. Do you have diabetes?	YES	NO	

If you answered YES to question #9, please answer questions 10- 13 if you answered NO please skip to question #14.

10. Have you had an eye exam?	YES	NO	What Date: _____
11. Have you had a foot exam?	YES	NO	What Date: _____
12. Have you had your urine protein checked?	YES	NO	What Date: _____
13. Do you check your blood sugar every day?	YES	NO	What was today's reading? _____

Female patient's only

14. Have you had a mammogram?	YES	NO	What Date: _____ Facility: _____
15. Have you had a pap smear?	YES	NO	What Date: _____ Facility: _____
16. Have you had a DEXA scan? (DEXA=Bone Density Scan)	YES	NO	What Date: _____ Facility: _____

For all patients

- PHQ-2 Depression Screening:

1. During the past month, have you often been bothered by feeling down, depressed, and hopeless?	YES	NO
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	YES	NO
3. Are you satisfied with your life?	YES	NO
4. Do you feel lonely or isolated?	YES	NO

- Fall Risk Assessment:

1. Have you fallen in the past year? YES NO
2. Do you feel unsteady when standing, walking, or climbing stairs? YES NO
3. Do you fall when you get up or when you are walking? YES NO
4. Do you worry about falling? YES NO

- Pain Assessment:

1. Pain intensity (0 lowest to 10 highest) _____ Present pain _____ Worst pain_____ Best pain_____
2. Quality of pain (stabbing, sharp, dull, constant, etc…) _____
3. What causes the pain? _____
4. What relieves pain? _____

Have you had a recent ER or Urgent care visit? Include Reason, Date, and Location: _____
_____

Are you on any new medications? Include Name and Dosage: _____
_____

Pharmacy: Name: _____ Number: _____ Address: _____

Circle YES or NO for the following questions.

Do you feel you are a fragile person?	YES	NO
Do you have problems moving your arms, legs, or head?	YES	NO
Do you suffer from pain or fatigue?	YES	NO
Do you get any physical activity? (Ex: walking, yard work, or exercise)	YES	NO
Do you have stress above and beyond normal every day stress?	YES	NO
Do you have anger issues?	YES	NO
Do you do your own shopping?	YES	NO
Do you eat balanced meals?	YES	NO
Do you prepare your own food?	YES	NO
Do you feed yourself?	YES	NO
Do you have any oral health issues?	YES	NO
Are you responsible for your own medications?	YES	NO
Do you bathe yourself?	YES	NO
Do you dress yourself?	YES	NO
Do you groom yourself?	YES	NO
Do you go to the bathroom yourself?	YES	NO
Do you do your own housekeeping and laundry?	YES	NO
Do you have any problems with transportation?	YES	NO
Do you wear your seatbelt when you are in the car?	YES	NO
Do you handle your own finances?	YES	NO
Do you use a telephone?	YES	NO
Do you have a home safety plan in the event there is a fire or tornado?	YES	NO

_____ _____

Patient/Guardian Signature Date