GAUTAM
MEDICAL & WELLNESS

PATIENT INFORMATION

Welcome to our office.
In order to serve you properly, we need the following information. All information is strictly confidential.

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Name of Spouse (or Parent/Guardian)

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

FINANCIAL

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Gautam to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits.

Patient/Guardian signature _____ Date _____

Health History

Welcome to our practice. As a new patient please fill out the information found below.

Patient Name	**Birthdate**	**Patient #**
Chief Complaint		
History of Present Illness		
Location:	**Quality:**	
Where is the pain/problem	Example: normal versus abnormal color, activity, etc.	
Severity:	**Duration:**	
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)	(How long have you had this pain/problem, or when did it start?	
Timing:	**Context:**	
(Does the pain/problem occur at a specific time?)	(Where were you at the onset of this pain/problem?)	
Associated sign/symptoms:	**Modifying Factors**	
(What other associated problems have you been having?)	(What makes the pain/problem worse or better? or have you had previous episodes?	

Past Medical History

Have you ever had the following (Circle "no" or "yes"

Measles	No	Yes	Anemia	No	Yes	Back Trouble	No	Yes	Hepatitis	No	Yes
Mumps	No	Yes	Bladder infection	No	Yes	High blood pressure	No	Yes	Ulcer	No	Yes
Chickenpox	No	Yes	Epilepsy	No	Yes	Low blood pressure	No	Yes	Kidney Disease	No	Yes
Whooping Cough	No	Yes	Migraine Headache	No	Yes	Hemorrhoids	No	Yes	Thyroid Disease	No	Yes
Scarlet Fever	No	Yes	Tuberculosis	No	Yes	Date of last chest x-ray _____			Bleeding Tendency	No	Yes
Diphtheria	No	Yes	Diabetes	No	Yes	Asthma	No	Yes	Any Other Disease?	No	Yes
Smallpox	No	Yes	Cancer	No	Yes	Hives or Eczema	No	Yes			
Pneumonia	No	Yes	Polio	No	Yes	AIDS or HIV+	No	Yes			
Rheumatic Fever	No	Yes	Glaucoma	No	Yes	Infectious Mono	No	Yes			
Heart Disease	No	Yes	Hernia	No	Yes	Bronchitis	No	Yes			
Arthritis	No	Yes	Blood or Plasma Transfusions	No	Yes	Mitral Valve Prolapse	No	Yes			
Venereal Disease	No	Yes	Stroke	No	Yes						

Previous Hospitalization/Surgeries **When?** **Hospital, City, State**

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? No Yes

Patient Social History:

Marital Status	Single	Married	Separated	Divorced	Widowed	
Use of alcohol	Never	Rarely	Moderate	Daily		
Use of tobacco	Never	Previously, but	Quit	Current packs/day		
Use of drugs	Never	Type/Frequency				
Excessive Exposure at Home or work to	Fumes	Dust	Solvents	Air-borne Particles	Noise	

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Symptoms: Please indicate only personal History Below

Constitutional Symptoms:		
Good general Health lately?	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes		
Eye disease or injury	No	Yes
Wear Glasses/Contact Lenses	No	Yes
Blurred or double vision	No	Yes

Ears/Nose/Mouth/Throat		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes

Genitourinary		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male-testicle pain	No	Yes
Female pain with periods	No	Yes
Female irregular periods	No	Yes
Female vaginal discharge	No	Yes
Female –number of pregnancies		
Female- number of miscarriages		
Female- date of last pap smear		

Psychiatric		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Endocrine		
Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold tolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes
Hematologic/ Lymphatic		
Slow to heal after cuts	No	yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes
Allergic/ Immunologic		
History of skin reaction or other adverse reaction to		
Penicillin or other antibiotics	No	Yes
Morphine, Demerol or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxins or other serums	No	Yes

Cardiovascular		
Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes
Respiratory		
Do you have a persistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Gastrointestinal		
Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea and vomiting	No	Yes
Painful bowel movement or constipation	No	Yes
Rectal bleeding or blood in stool abdominal pain	No	Yes

Musculoskeletal		
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	yes
Muscle pain or cramps	No	Yes
Back pan	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes
Integumentary (skin, breast)		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes
Neurological		
Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

Iodine, merthiolate or other antiseptic	No	Yes
Other drugs/medications	No	yes

Known Food Allergies:

Environmental allergies

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Patient Signature Date:

_____ _____

Doctor's Signature Date

GAUTAM
MEDICAL & WELLNESS
930 W. Main Street, Barstow CA 92311
Tel: (760)256-1004; Fax: (760)256-1055

Ravindra Gautam, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

ATTN: Medical Records
930 W. Main Street
Barstow, CA 92311
Fax: 760-256-1055

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:

  _____

- ☐ All healthcare information
- ☐ Other

This authorization will remain in effect:

- ☐ From the date of this authorization until: _____
- ☐ Until the following event occurs: _____

  Unless otherwise noted above, this authorization will remain in effect 180 days from the date signed.

Signature of Patient: _____ Date: _____
or Legal Representative

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

GAUTAM
MEDICAL WELLNESS

Ravindra Gautam, M.D., Inc.

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. H.I.P.P.A, the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, out in place controls to ensure that your personal medical information is safe.

Ravindra Gautam, M.D., Inc requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: _____ **Date:** _____

Name of Patient or Representative: _____ **Date:** _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to obtain or inquire about the patient's medical history. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical history released to family members you must sign this form. Signing this form will only give consent to release medial history and test results to the family members indicated below. This consent form will not allow Ravindra Gautam, M.D., Inc. to release any other information to these family members. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Ravindra Gautam, M.D., Inc. to release my laboratory/radiology results and reports to the following individuals.

1. _____ **Relation to Patient:** _____ **Phone #:** _____
2. _____ **Relation to Patient:** _____ **Phone #:** _____

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

GAUTAM
MEDICAL WELLNESS

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Ravindra Gautam, M.D., Inc. to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call Ravindra Gautam, M.D., Inc. regarding an issue or concern. At no time will a representative of Ravindra Gautam, M.D., Inc. discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

PATIENT SIGNATURE: _____

PATIENT NAME:_____

DATE:_____

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for –

Items or Services:
Office Visit
Because:
Office Visit

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't under stand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

GAUTAM
MEDICAL WELLNESS

Walking Impairment Questionnaire (WIQ)

Patient Name _____ Date of Birth _____

Walking Impairment: These questions ask about the reasons why you are having difficulty walking. We would like to know how much difficulty you had walking during the past week. By difficulty, we mean how hard it was or how much physical effort it took to walk because of each of these problems.

Peripheral Arterial Disease (PAD) Specific Questions

		Degree of Difficulty				
		None	Slight	Some	Much	Very
Pain, aching or cramps in your calves or buttocks?	Right Leg	4	3	2	1	0
	Left Leg	4	3	2	1	0
	Both Legs	4	3	2	1	0

Differential Diagnosis

	Degree of Difficulty				
	None	Slight	Some	Much	Very
1. Pain, stiffness or aching in your joints (ankles, knees or hips)?	4	3	2	1	0
2. Weakness in one or both of your legs?	4	3	2	1	0
3. Pain or discomfort in your chest?	4	3	2	1	0
4. Shortness of breath?	4	3	2	1	0
5. Heart palpitations?	4	3	2	1	0
6. Other problems (please list)	4	3	2	1	0

Walking Distance: Report the degree of physical difficulty that best describes how hard it was for you to walk on level ground without stopping to rest for each of the following distances during the last week.

Distance

	Degree of Difficulty				
	None	Slight	Some	Much	Very
1. Walking indoors such as around your home?	4	3	2	1	0
2. Walking 50 feet?	4	3	2	1	0
3. Walking 150 feet (1/2 block)?	4	3	2	1	0
4. Walking 300 feet (1 block)?	4	3	2	1	0
5. Walking 600 feet (2 blocks)?	4	3	2	1	0
6. Walking 900 feet (3 blocks)?	4	3	2	1	0
7. Walking 1500 feet (5 blocks)?	4	3	2	1	0

Walking Speed: Report the degree of difficulty that best describes how hard it was for you to walk one city block on level ground at each of these speeds without stopping to rest during the last week.

Speed

	Degree of Difficulty				
	None	Slight	Some	Much	Very
1. Walking one block slowly?	4	3	2	1	0
2. Walking one block at an average speed?	4	3	2	1	0
3. Walking one block quickly?	4	3	2	1	0
4. Walking or jogging one block?	4	3	2	1	0

Stair Climbing: For each of these questions, report the degree of physical difficulty that best describes how hard it was for you to climb stairs without stopping to rest during the past week.

Stairs

	Degree of Difficulty				
	None	Slight	Some	Much	Very
1. Climbing one flight of stairs?	4	3	2	1	0
2. Climbing two flights of stairs?	4	3	2	1	0
3. Climbing three flights of stairs?	4	3	2	1	0

GAUTAM
MEDICAL WELLNESS

Upper Extremity Questionnaire

Do you experience any of the following:

YES___ NO___ NUMBNESS OF ARMS AND HANDS

YES___ NO___ TINGLING OF ARMS AND HANDS

YES___ NO___ POSITIONAL WEAKNESS OF ARMS AND HANDS

YES___ NO___ SWELLING OF FINGERS AND HANDS

YES___ NO___ HEAVINESS OF UPPER EXTREMITY

YES___ NO___ COLDNESS OF HANDS

YES___ NO___ TIREDNESS, HEAVINESS AND PARESTHESIA ON ELEVATION OF ARMS

YES___ NO___ HEADACHES

YES___ NO___ FUNNY FEELINGS IN FACE AND EAR

YES___ NO___ DIZZINESS, LIGHTHEADNESS/VERTIGO

THORACIC OUTLET SYNDROME SYMPTOMS

The predisposing factors responsive for the development of thoracic outlet syndrome are fibro muscular bands, bony protuberances and long or larger transverse processes, this together with the tendinous or cartilaginous muscular insertions are responsible for the compression of the neurovascular structures at the thoracic outlet.

These abnormalities or variations of the anatomy of this area produce symptoms of thoracic outlet syndrome that have been triggered by trauma or repetitive work. The symptoms may spontaneously occur because there are patients who have symptoms of thoracic outlet syndrome without a history of trauma or repetitive work. The compression occurs in three anatomical structures, arteries, veins and nerves; isolated, or more commonly two or three of the structures are compressed. Compression can be of different magnitude in each of these structures. Therefore symptoms can be protean.

Ravindra Gautam, M.D.

Name:_____

Phone Number: _____

GAUTAM
MEDICAL & WELLNESS

Adult TB Exposure Risk Assessment

(Evaluation Questionnaire to determine if Tuberculin Mantoux skin test (TST) is indicated)

Name: _____ **Medical Record #:**_____

Age: _____ **DOB:** _____ **Date of Service:** _____

The health care worker (HCW) is to ask the following questions during each periodic health assessment:

1. Have you or anyone you see regular been diagnosed or suspected of being sick with active diseases?
   Yes_____ No_____
2. Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?
   Yes_____ No_____
3. Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?
   Yes_____ No_____
4. Do you live in out of home placements (such as foster care or residential facilities?
   Yes_____ No_____
5. Do you have HIV infection or other immunosuppressive condition(s)?
   Yes_____ No_____
6. Do you live with someone with HIV seropositivity?
   Yes_____ No_____
7. Do you live or frequently visit with persons who have been incarcerated in the last 5 years?
   Yes_____ No_____
8. Do you live among or been frequently around individuals who are homeless, migrant workers, user of street drugs, or residents in nursing homes?
   Yes_____ No_____
9. Do you consume alcoholic beverages?
   Yes_____ No_____

INSTRUCTIONS TO HEALTH CARE WORKER:

Administer the Mantoux TB skins test to all adults who have any of the above risk facts (indicated by YES response) UNLESS

1. The patient has previously **DOCUMENTED*** positive Mantoux TST, or
2. The patient has had a TST within the last year.

Note:
Trained medical personnel must read the skin test.
***DOCUMENTED** = Record indicated date of Mantoux and the millimeter results.

Health Care Worker completing form: _____

Date: _____

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name _____ **Today's Date** _____

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

☐ **1. DEPRESSED MOOD**
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

☐ **2. FEELINGS OF GUILT**
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment: delusions of guilt
4 = Hallucinations of guilt

☐ **3. SUICIDE**
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

☐ **4. INSOMNIA - Initial**
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

☐ **5. INSOMNIA - Middle**
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **6. INSOMNIA - Delayed**
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

☐ **7. WORK AND INTERESTS**
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

☐ **8. RETARDATION**
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

☐ **9. AGITATION**
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **10. ANXIETY - PSYCHIC**
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

11. ANXIETY - SOMATIC
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

12. SOMATIC SYMPTOMS - GASTROINTESTINAL
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

13. SOMATIC SYMPTOMS - GENERAL
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

14. GENITAL SYMPTOMS
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

15. HYPOCHONDRIASIS
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

16. WEIGHT LOSS
0 = No weight loss
1 = Slight
2 = Obvious or severe

17. INSIGHT
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: _____
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

18. DIURNAL VARIATION
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation: AM ( ) PM ( )
2 = Severe variation: AM ( ) PM ( )

19. DEPERSONALIZATION AND DEREALIZATION
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

20. PARANOID SYMPTOMS
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

21. OBSESSIONAL SYMPTOMS
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*, 23:56-62, 1960.

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

GAUTAM
MEDICAL WELLNESS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at **760-256-1004**.

If you have any questions about my *Notice of Privacy Practices,* please contact me at:

930 W. Main Street
Barstow, CA 92311

I acknowledge receipt of the *Notice of Privacy Practices* of Our Healthcare Consultants

Signature: _____ **Date:** _____
(Patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgment of his or her receipt of my *Notice of Privacy Practices,* including _____

_____.

However, because of _____ I was unable to obtain my patient's acknowledgment.

Signature of Provider: _____ **Date:** _____

GAUTAM
MEDICAL WELLNESS

RAVINDRA M. GAUTAM, MD, INC

ADVANCE DIRECTIVE ACKNOWLEDGEMENT FORM

I acknowledge that I have received information on Advance Directive policy.

_____ _____

Patient/Patient Representative Signature Date

I do not have an Advance Directive. Information has been offered to me.

_____ _____

Patient/Patient Representative Signature Date

I have an Advance Directive and will bring it on another day.

_____ _____

Patient/Patient Representative Signature Date