To be considered for Services at the clinic you must provide the following information. Without this information we cannot determine your eligibility and cannot schedule a medical appointment for you.

Along with this the person wanting the medical appointment needs to be present for the eligibility determination. A $10 fee is required at the time you are determined eligible for the clinic services

*** Proof of residency within Shenandoah County** this is two pieces of recent postmarked mail, a utility bill with your name on it and service address or a copy of your lease or mortgage or regular mail, in any combination as long as you have two documents. Recent is within the last two months

*** Proof of Income for the entire household for a month** this can consist of a month worth of pay stubs for you and/or spouse. If you are not working then a letter of support from whomever is offering you shelter. Copies of the recent benefit letter with the current payment from SSDI, SS, unemployment, child support, pensions, Schedule C of your IRS form 1040 if you are self-employed etc. If you receive food stamps please bring a copy of your eligibility

*** A copy of your most recent Federal Income Tax Return**

This information will also need to be provided at each of your recertification's.

New patient Eligibility is determined Wednesday's from 1-3

SHENANDOAH COMMUNITY HEALTH CLINIC

Services NOT Offered :

1. Birth Control
2. Obstetrics
3. Immunizations/TB test
4. Well-child checks
5. VDOT physicals
6. Disability physicals

Servicios NO ofrecidos:

1. Control de Natalidad
2. Obstetricia
3. Immunizaciones/pruebas TB
4. Chequeos de ninos
5. Fisicos de devision de transporte
6. Fisicos para desabilidad

Conditions/Diagnoses NOT Treated:

1. ADD or ADHD
2. STDs
3. Severe psychological disorders
4. Alzheimer's/Dementia

Condiciones/Diagnosticos NO tratados

1. Trastorno de deficit de atttencion
2. ETS
3. Trastornos psicologicos grave
4. Alzheimers/Demencia

Medications NOT prescribed or provided by this Clinic:

1. "Benzos" (i.e.: Xanax, Clonazepam, Ativan)
2. Controlled Substances/Narcotics (i.e.—Hydrocodone, Percocet, etc.)
3. Stimulants (i.e.: Ritalin, Adderall, etc.)

Medicaciones No Recetados o despensado por esta Clinica

1. "Benzos" (e.i.: Xanax, Clonazepam, Ativan
2. Sustancias Controladas/Narcoticos (e.i.: Hydrocodone, Percocet, etc)
3. Stimulantes (e.i.: Ritalin, Adderall, etc)

This Clinic reviews Virginia Prescription Monitoring Program for patient use of controlled substances.

Esta Clínica' utiliza el Programa de Virginia Monitoreo de Recetas para pacientes con sustancias controladas.

I understand that the above are services that are not prioivided by the clinic and I cannot be helped here for these reasons.

______________________________ ______________________

Signature of Patient **Date**

Needs Interpreter
Yes____ **No**____

SCFC Eligibility Intake Interview
CLINICA GRATUITA DEL CONDADO DE SHENANDOAH
ENTREVISTA DE ADMISION Y ELIGIBILIDAD

Today's Date/*Fecha de Ahora:*_____/_____/_____

Patient/Paciente: ______________ ______________ ______________
Name/*Nombre* *Middle name* Last Name/*Primer Apellido*

Parent/Guardian (if applicable)/***Padre/Encargado (si aplica)***______________

Address/*Direccion* (Street/*Calle, P.O. Box, Apt #*)______________

City/*Ciudad)* ______________ ZIP__________ **Telephone/***Telefono:*__________

Cell Phone/*Telefono Celular:*______________ **Gender/***Genero* **Male/***Masculino* **Female/***Femenino*

Social Security Number/*Numero de Suguro Social*______________

Date of Birth/*Fecha de Nacimiento* _____/_____/_____ **Age/***Edad* __________

Employed: Full time/*Trabaja Tiempo Completo:*______ **Part Time/***Trabaja Medio Tiempo:*______

Unemployed/*Desempleado:*______ **For How Long/***Por Cuánto Tiempo?*______________

Legally Declared Disabled/*Incapacitado(a)*__________ **Child/***Niño(a)*__________

Employer/*Lugar de Empleo*______________

How Long/*Cuanto Tiempo*__________ **Work Phone/** *Telefono del Trabajo*__________

Marital Status/*Estado Civil* **Single/***Soltero(a)* **Married/***Casado(a)* **Separated/***Separado(a)*

Divorced/*Divorciado(a)* **Widowed/***Viudo(a)* **Cohabitation/***Acompanado(a)* **Dependent/***Dependiente*

Head of Household (if not patient) employed
Cabeza de Familia (si no es paciente) trabaja

Full time
*tiempo completo*__________

Part time
*medio tiempo*__________

Unemployed/*Desempleado(a)*______________ **Disabled/***Incapacitado(a)*______________

*****You must have proof of the entire family's income to be seen today*****
Usted debe de tener prueba de todo ingreso familiar para poder ser atendido/a ahora

OFFICE USE ONLY
Date Eligibility Card Expires: ___/___/___

Poverty Level______________%

Has Insurance Yes____ No____

Interviewer: ______________

\# in household__________

Annual Income for household ______________

Emergency Contact Name/ ***Nombre de contacto en caso de emergencia*** ____________________

Relationship/*Relacion* ____________________

Emergency contact's home phone/ ***Numero telefonico del contacto*** de emergencia____________________

Work Phone/ ***Numero telefonico de trabajo del contacto*** ____________________

Are you a veteran? _______ **If yes, have you applied with the VA and been denied services?**________
Laws continue to change and you may miss benefits if you are not enrolled for updates from them.

How long have you lived in Shenandoah County?
Cuanto tiempo ha vivido en el Condado de Shenandoah? ____________________

Education (highest level achieved)/*Educacion (grado mas alto logrado)*
Grade level/*grados* 1 – 5_____ 6 – 8_____ 9 – 12_____ Unknown/*Desconocido*_______

High school graduate/*Graduado(a) de Bachillerato/Preparatoria* ______

Some college/*Un poco de Universidad*_________ College graduate/*Graduado(a) de Universidad*_________

What language do you speak? *Que idioma habla usted?* ____________________ **If you do not speak /understand English, is there a friend or family member who can interpret for you? If so, please give information below/***Si usted no puede hablar/entender el Ingles, hay un amigo(a) o familiar que pueda interpretarle? Si es asi, Por favor dar la siguiente informacion*:

Interpreter/*Interprete*____________________ **Interpreter's phone # /** *Telefono del interprete*___________

Where Did you go the last time you needed to see a doctor?
Donde fue usted la última vez que necesito ver a un médico ?

1. Emergency room? Reason / *Cuarto de Emergencias? Razon* ____________________
2. Private Office? Why did you not return there/ Oficina privada? Por que no regreso a la misma?_____

Where would you go if the Free Clinic were not available?
Donde habría ido si la Clínica Gratuita no estuviera disponible?

Private M.D._________ *Médico Privado* ______ Emergency Room_______ *Cuarto de Emergencias*_____ Health Department_________ *Departamento de Salud*____ Any Where__________ *En Ninguna Parte*____

Please list the people in your immediate family who live in your house.
Por Favor enumere las personas de su familia inmediata que viven en su casa.

Name/*Nombre*	**Relationship/*Relacion***	**Age/*Edad***

Do you have any medical insurance? Please present your insurance card.

Tienes asesuganza medica? *Por favor presente su tarjeta de aseguranza.*

Medicaid ________ Plan First ________ Medicare________

Medicaid ________ Planeficacion Familiar ______Medicare________

Private Insurance /deductible________________ Prescription Insurance ____________

Aseguranza Privada/deducible________________ Aseguranza de Recetas Medicas____________

Income types (please circle all that apply)

Tipos de ingresos (circula todos que apliquen)

Wages from employment Self-employment Unemployment

Sueldo de empleo Trabajo por cuenta propia Desempleo

Social security disability; When were you declared legally disabled? ______________

Desabilidad de Seguro Social: Cuando te declararon con desabilidad legal?______________

Social security supplemental income Social security retirement

Ingreso de Seguro Social Suplemental Retiro de Seguro Social

Pension living off of checking/savings Annunity Other

Pencion Viviendo de ahoros Anualidad Otro

Do you have over $2500 in savings/investments Yes No

Tienes mas de $2500 in ahoros/inverciones Si No

I affirm that the information that I have provided is accurate to the best of my knowledge.

Yo afirmo que la informacion dada es correcta y lo major de mi conosimiento.

Signature ______________________________ Date______________

PATIENT HEALTH HISTORY

NAME: / *NOMBRE:* ____________________ DATE OF BIRTH / *FECHA NACIMIENTO* ____________________

HOME PHONE: / *TELEFONO DE CASA:* ____________________ ALTERNATIVE PHONE: / *ALTERNATIVO:* *TELEFONO* ____________________

PHYSICIAN YOU HAVE SEEN IN THE PAST: / *ALGUN MEDICO QUE HAYA VISTO EN EL PASADO:* ____________________ LAST APPT THERE: / *ULTIMA CITA:* *SU* ____________________

IN CASE OF EMERGENCY, CONTACT: / *EN CASO DE EMERGENCIA,CONTACTAR:* ____________________ PHONE: / *TELEFONO:* ____________________

Please check and answer questions below.
Por favor Revisa y conteste todas las preguntas a continuacion.

PAST HISTORY

HISTORIAL MEDICO PASADOS

(Have you ever had?)
(*Alguna vez ha tenido?)*

	YES	NO
HIGH BLOOD PRESSURE *PRESION ALTA*	☐	☐
HEART TROUBLE OF ANY TYPE *PROBLEMAS DE CORAZON*	☐	☐
DISEASE OF THE ARTERIES *ENFERMEDADES ARTERIALES*	☐	☐
LUNG DISEASE *ENFERMEDAD PULMONAR*	☐	☐
ASTHMA *ASMA*	☐	☐
HEPATITIS *HEPATITIS*	☐	☐
DIABETES *DIABETES*	☐	☐
HEART MURMER *SOPLO AL CORAZON*	☐	☐
ARTHRITIS *ARTRITIS*	☐	☐

FAMILY HISTORY

HISTORIAL MEDICO FAMILIARES

(Have any of your immediate family or grandparents had?)

(Han tenido o tienen alguin de su familia inmediata o abuels?)

	YES	NO
HEART ATTACK *ATAQUES DE CORAZON*	☐	☐
HIGH BLOOD PRESSURE *PRESION ALTA*	☐	☐
STROKE *DERRAME CELEBRAL*	☐	☐
DIABETES *DIABETES*	☐	☐
CANCER *CANCER*	☐	☐
CONGENITAL HEART DEFFECT DEFECTOS CONGENITALES DEL CORAZON..........	☐	☐
HEART SURGERY *CIRUGIAS AL CORAZON*	☐	☐
OTHER FAMILY ILLNESS:(SPECIFY) *OTRAS ENFERMEDADES FAMILIARES*	☐	☐

PATIENT HEALTH HISTORY, CONT.

PRESENT SYMPTOMS *SYNTOMAS PRESENTES*
(Have you recently had?) (Has tenido recientemente?)

	YES	NO
CHEST PAIN?DISCOMFORT *DOLOR EN EL PECHO/MALESTAR*		
SHORTNESS OF BREATH *DIFICULTA PARA RESPIRAR*		
HEART PALPITATIONS *PALPITACIONES AL CORAZON*		
IRREGULAR HEART BEATS *LATIDOS IRREGULARES AL CORAZON*		
FREQUENT HEADACHES *FRECUENTES DOLORES DE CABEZA*		
DIZZY SPELLS *MAREOS*		
BACK PAIN *DOLOR DE ESPALDA*		
OTHER PAIN *ALGUN OTRO DOLOR*		
FREQUENT COLDS *REFRIADOS FREQUENTES*		

SURGERIES: *CIRUGIAS:*

Please list any hospitalizations/surgeries: Por favor mencionar cualquier hospitalizaciones recientes /Cirugias:

DATE: *FECHA:*	WHERE: *DONDE:*	WHY: *MOTIVO:*

ANY OTHER MEDICAL PROBLEMS/CONCERNS NOT ALREADY IDENTIFIED? YES____ NO_____
ALGUN OTRO PROBLEMA MEDICA/PREOCUPACIONES QUE NO HAYAN SIDO MENCIONADO

(please describe)
(por favor describa)

PATIENT HEALTH HISTORY, CONT.

DO YOU CURRENTLY SMOKE?
USTED FUMA ACTUALMENTE?

YES____ NO____ If yes, --Si es asi,--
How much per day_____/day *Cuantos cigarros al dia?_____/dia*

HAVE YOU EVER QUIT SMOKING?
ALGUNA VEZ HAS DEJADO DE FUMAR?

YES____ NO____ When?______ *Cuando?_______* _____

How many years did you smoke?
Cuantos a ños usted fuma?____ ____

DO YOU DRINK ALCOHOLIC BEVERAGES?
USTED TOMA BEBIDAS ALCHOLOLICAS?

YES__ NO __ If yes, how much in one week?
SI___NO___Si es asi cuanto a la semana?

Beer ____ cans
Cerveza_____Latas

Wine ____ glasses *Vino_____copas/vasoa*

Hard Liquor ____drinks
Licor______Copitas

DO YOU DRINK CAFFEINATED BEVERAGES?
USTED TOMA BEBIDAS CON CAFEINA?

YES__ NO __ If yes, how much in one day?
Si es asi, cuantos al dia?

Coffee___cups *Café_____Tazas*
Tea______Glasses *Te______Vasos*
Soda ___ cans/bottles
Gaseosa____Latas____Botellas

DRUGS:
CONSUMO DE DROGAS:

Do you currently use marijuana or *Actualmente usted consume marihuana* recreational drugs? *o drogas recreativas?* YES__ NO __

Have you ever used marijuana or *Alguna vez a usado marihuana* recreational drugs? *o drogas recreativas?* YES__ NO __

Have you ever used needles to inject drugs? *Alguna vez has utilizado agujas para inyectarse drogas?* YES__ NO __

PATIENT HEALTH HISTORY, CONT.

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ___ NO ___
ES ALLERGICO A ALGUN MEDICAMENTO?

IF YES, WHAT? SI
ES ASI, A CUAL? ____________________

ARE YOU TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS? (including birth control)
USTED ESTA TOMANDO ALGUN MEDICAMENTO CON RECETA MEDICA O SIN RECETA MEDICA (Incluyendo control natal)

YES_____ NO _____

If so, please list below or show prescription bottles to nurse
Si es asi, por favor indique a continuacion o mostrar la recetas de los frascos de medicamentos a la enfermera(o)

Medication Name & Dose *El nombre del medicamento y la dosis*	Reason for taking medication *Razon porque lo toma?*	For how long? *Por cuanto tiempo*

I have filled out this form to the best of my knowledge:
He completado este formulario de acuerdo a mi mejor entendimento.

Signature
FIRMA: ____________________

Date
FECHA: ____________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: ______________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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 figety 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	0	1	2	3

add columns + +

PLEASE ANSWER QUESTION #10 also!

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, 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 ______

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Shenandoah Community Health Clinic
Shenandoah County Free Clinic

Patients Name ______________________________ DOB ________________

CONSENT TO EXCHANGE INFORMATION

BETWEEN HOSPITALS, HUMAN SERVICE AGENCIES AND FREE CLINICS

By Signing this form I am allowing the Winchester Medical Center, Shenandoah Memorial Hospital, other hospitals and other health and human services agencies to exchange certain information with the Shenandoah County Free Clinic and for the Shenandoah County Free Clinic to exchange certain Information with Winchester Medical Center, Shenandoah Memorial Hospital and other hospitals and health and human services agencies as needed, so it will be easier for them to provide or coordinate services in a timely manner. This information includes, but not limited to, resource information; financial information; benefits/services needed; health records; billing information, employment records and eligibility for assistance programs and dates eligible.

1. I ____ am signing
   (full printed name of consenting person)

   This form for the following agencies: Winchester Medical Center and Shenandoah Memorial Hospital, other hospitals ,medical practices and health and human services agencies and the Free Clinic(s) where I am receiving health services, to share with each other the information needed as indicated above.

My Relationship to the client is ____ Self ____ Parent ____ Power of Attorney

____ Guardian ____ Other Legally Authorized Representative

Signed: ______________________________________ Date: ______________

This consent may be withdrawn at any time in writing to the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a valid consent to share information