HEALTHCARE CENTERS
of MORRIS HOSPITAL

Morris Hospital and Healthcare Centers Registration Form

Patient Information

Last Name:	**First Name:**	**M.I.:**	**Maiden/Previous Name (if applicable):**
Mailing Address:	**Apt/Unit #:**	**City/State/Zip:**	
Primary Contact Number:	**Secondary Contact Number:**	**Work Number:**	**Ext.:**

Preferred Phone Number for Appointment Reminders: ☐ Primary Number ☐ Secondary Number ☐ Other:_____
Preferred Delivery Method for Appointment Reminders: ☐ Voice Message ☐ Text Message

Primary Care Physician:	**Referring Physician:**	**Patients Date of Birth:**
Sex: ☐ Male ☐ Female ☐ Transgender	**Marital Status:** ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated	**Social Security Number:**
Employer Name:	**Employer Address:**	**Employer Phone #:**

Employment Status: ☐ Full-Time ☐Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Other: _____

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student	**Email Address for Patient Portal :**

Race (please select): ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Decline to Specify ☐ Other _____

Ethnicity (please select one): ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Decline to Specify	**Preferred Language (please select one):** ☐ English ☐ Spanish ☐ Decline to Specify ☐ Other: _____	**Translator:** ☐ Yes ☐ No **if a translator is needed, one will be provided.*

Preferred Pharmacy Name and Location: (please include any mail order pharmacy)

Advanced Directives: (*If yes, please provide the office with a copy for your record*)
☐ Medical Power of Attorney ☐ Do Not Resuscitate ☐ Living Will ☐ Not Applicable ☐ None

The following Parent Section is to be compelted ONLY if the patient is a minor (under the age of 18). Please note that any individuals outside of the two named parents will need to be added to the Release of Information Form.

Parent/Legal Guardian #1

Parent/Legal Guardian #1 First and Last Name:	**Birthdate:**	**Relationship:**
Mailing Address: (Same as Patient ☐ Yes)	**Apt/Unit #:**	**City/State/Zip:**
Main Contact Number: ☐ Same as Patient	**Secondary Number (if applicable):**	

Parent/Legal Guardian #2

Parent/Legal Guardian #2 First and Last Name:	**Birthdate:**	**Relationship:**
Mailing Address: (Same as Patient ☐ Yes)	**Apt/Unit #:**	**City/State/Zip:**
Main Contact Number: ☐ Same as Patient	**Secondary Number (if applicable):**	

Parent/Legal Guardian Marital Status: ☐ Married ☐ Divorced ☐ Partner ☐ Unmarried ☐ Widowed ☐ Legally Separated

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Responsible Party

***Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor and is responsible for the bill. Statements will be sent to the responsible party listed. ***

Is the responsible party a patient with the Morris Hospital Healthcare Centers? ☐ Yes ☐ No				**Same info as above** ☐ Yes
Last Name:	**First Name:**		**M.I.:**	**Previous Name (if applicable)**
Date of Birth:	**Social Security Number:**	**Primary Phone:**	**Email:**	**Gender:** ☐ Male ☐ Female ☐ Transgender
Mailing Address:		**Apt/Unit#:**	**City/State/Zip Code:**	
Employer Name:		**Employer Address:**		
Work Phone:	**Ext.:**	**Okay to Leave Message at Work:** ☐ Yes ☐ No	**Responsible Party's Relation to Patient:**	

Emergency Contact

Is the emergency contact a patient with the Morris Hospital Healthcare Centers? ☐ Yes ☐ No			
Relation to Patient:	**Last Name:**	**First Name:**	**Date of Birth:**
Main Contact Number:	**Work Phone:**		**Ext.:**
Mailing Address: (Same as Patient ☐ Yes)	**Apt/Unit #:**	**City/State/Zip:**	

Primary Insurance

Primary Insurance Company:		**Primary Insurance Address:**	**Phone Number:**
Subscriber Number:		**Group Number:**	**Copay(s):**
Policy Holders Name: ☐ Same as Patient		**Is this person a patient with the Healthcare Centers?** ☐ Yes ☐ No	
Date of Birth:	**Social Security Number:**	**Primary Contact Number:**	
E-mail:	**Gender:** ☐ Male ☐ Female ☐ Transgender	**Mailing Address:**	
Employer Name:	**Employer's Address:**	**Work Phone:**	**Ext.:**

Secondary Insurance

Secondary Insurance Company:		**Secondary Insurance Address:**	**Phone Number:**
Subscriber Number:		**Group Number:**	**Copay(s):**
Policy Holders Name: ☐ Same as Patient		**Is this person a patient with the Healthcare Centers?** ☐ Yes ☐ No	
Date of Birth:	**Social Security Number:**	**Primary Contact Number:**	
Email:	**Gender:** ☐ Male ☐ Female ☐ Transgender	**Mailing Address:**	
Employer Name:	**Employer's Address:**	**Work Phone:**	**Ext.:**

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Initials:

_____ I understand that it is the policy of the Healthcare Centers of Morris Hospital to be given at least 24 hour notice when canceling an appointment. I understand that more than 3 failures to cancel appointments without proper notice may result in being discharged from the practice.

_____ This Healthcare Center is a lab drawing station for Morris Hospital and all labs will be processed by the Morris Hospital laboratory. I am aware that my insurance may prefer or require an outside lab to be used for lab processing and that I am responsible for the charges that my insurance does not pay.

_____ I have read and been offered a current copy of the Notice of Privacy Practices.

_____ I have read and been offered a current copy of the Patient Rights and Responsibilities.

_____ I understand that my medication history will be verified electronically for treatment purposes.

_____ I understand that my immunization records will be sent electronically to the State of Illinois Immunization Registry.

_____ _____

Patient or Parent/Guardian Signature **Date**

***By signing I attest to all information provided is true to the best of my knowledge.**

HEALTHCARE CENTERS
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MEDICAL & FAMILY HISTORY FORM

Name: _____ **Today's Date:** _____

Last Medical Examination: _____ **Date Of Birth:** _____

Other Medical Providers	Specialty	Phone # / Location

MEDICATIONS Please list all of your current prescription and non-prescription medications, vitamins and supplements:

☐ None

Medication	Strength	Frequency	When did you start medication?

PAST MEDICAL HISTORY:

Birth History: (*Pediatric patients only***)**

Birth weight: _____ Delivering Physician/Hospital: _____

☐Full-Term (>38 weeks) ☐ Vaginal ☐ C-Section due to _____

☐Premature (<38 weeks) # weeks _____ ☐ Forceps ☐ Vacuum

Pregnancy Concerns: _____ ☐ None

Newborn Concerns: _____ ☐ Jaundice ☐ None

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PAST MEDICAL HISTORY:

☐ None

- ☐ Acid reflux
- ☐ Alcohol abuse
- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bedwetting
- ☐ Bi-pap/C-pap use
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast problem
- ☐ Cancer, Type:_____
- ☐ Chest Pain/Angina
- ☐ Chicken pox
- ☐ Cough
- ☐ Coronary Artery Disease /CAD
- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Congestive Heart failure/ CHF
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Ear infections, multiple
- ☐ Emphysema
- ☐ Eczema
- ☐ Fatty liver
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High triglycerides
- ☐ HIV or AIDS
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease /failure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Memory problems
- ☐ Migraines
- ☐ Milk intolerance
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Ovarian cyst
- ☐ Overweight
- ☐ Pancreatitis
- ☐ Parkinsons Disease
- ☐ Peptic Ulcer
- ☐ Peripheral Vascular Disease /PVD
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Pyloric stenosis
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ RSV
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sexual problems
- ☐ Sinusitis
- ☐ Sleep apnea
- ☐ Strep throat, multiple
- ☐ Stomach ulcer
- ☐ Stroke or paralysis
- ☐ TB – Tuberculosis
- ☐ TB skin test positive
- ☐ Thyroid disease
- ☐ Ulcerative colitis
- ☐ Urinary reflux
- ☐ Varicose veins
- ☐ Venereal disease
- ☐ Other_____

ALLERGIES (List all known allergies, including medication, food, animals, seasonal, etc.)

☐ None

Do you have a **latex** allergy? ☐ Yes ☐ No

Allergy	Reaction

SURGERIES/PROCEDURES

- ☐ None
- ☐ Appendectomy
- ☐ Breast
- ☐ Colon surgery
- ☐ Colonoscopy
- ☐ Colostomy
- ☐ C-section
- ☐ Defibrillator /Heart pacemaker
- ☐ Ear tubes
- ☐ EGD
- ☐ ERCP
- ☐ Gallbladder
- ☐ Groin hernia
- ☐ Heart bypass
- ☐ Heart stent
- ☐ Heart valve
- ☐ Hemorrhoid surgery
- ☐ Hiatal hernia
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Kidney
- ☐ Mastectomy
- ☐ Liver biopsy
- ☐ Obesity surgery/Gastric bypass
- ☐ Ovary
- ☐ Prostate
- ☐ Stomach
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Uterus
- ☐ Other_____

PREVIOUS HOSPITALIZATIONS OR SERIOUS INJURIES

☐ None

Hospitalization or Injury	Date

IMMUNIZATIONS

Pediatric Immunizations ☐ UNKNOWN Immunization history ☐ Immunization records available

Adult Immunizations/Vaccination Records ☐ UNKNOWN Immunization history

Check if received	Vaccination / Immunization	Date Received
☐	Influenza /Flu	
☐	Pneumonia	
☐	Tetanus	
☐	Shingles	
☐	Other -	
☐	Other -	

FAMILY HISTORY (Check the appropriate box to indicate which relative has had the following diseases)

Parents / Grandparents	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						
NO KNOWN HEALTH ISSUES						

Brothers / Sisters	☐Brother ☐Sister	☐Brother ☐Sister	☐Brother ☐Sister	☐Brother ☐Sister	☐Brother ☐Sister	☐Brother ☐Sister
	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						
NO KNOWN HEALTH ISSUES						

# Sons _____ # Daughters _____	☐Son ☐Daughter	☐Son ☐Daughter	☐Son ☐Daughter	☐Son ☐Daughter	☐Son ☐Daughter	☐Son ☐Daughter
	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____	☐Alive ☐Deceased Age:_____
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						
NO KNOWN HEALTH ISSUES						

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SOCIAL HISTORY

Daycare and Activities:	Daycare: ☐ At Home ☐ Day Care ☐ Elder Day Care ☐ Caretaker Activities: ☐Sports_____ ☐ Dance ☐ Band ☐ Scouts ☐Other_____
Education Level:	Highest grade level completed: ☐ Pre-School ☐ Grade School ☐ Home School ☐ High School ☐ College
Do you have smoke/carbon monoxide detectors in your home?	☐ No ☐ Yes
Exercise:	How many days a week do you exercise? _____ Type of exercise: _____ Duration: ☐ Less than 30 minutes each time ☐ More than 30 minutes each time
Living with:	☐ Alone ☐ Spouse ☐ Children ☐ Siblings ☐ Parents ☐ Mother ☐ Father ☐ Step-Parents ☐ Foster Parents ☐ Grandparents ☐ Caretaker ☐ Other _____
Marital Status:	☐ Married – How long? _____ ☐ Single ☐ Divorced ☐ Widowed
Occupation:	_____ ☐ Unemployed ☐ Retired
Pets:	☐ No ☐ Yes - Type: _____
Recreational Drug Use:	☐ No ☐ Yes; Specify drug(s) and amount(s): _____
Tobacco Use Screening:	☐ Never ☐ Former Smoker ☐ Current, Daily Smoker ☐ Current, Some Days Smoker *If former, how long has it been since you smoked?* ☐ < a month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 yrs ☐ 5-10 yrs ☐ >10 yrs *If current daily smoker, how many cigarettes a day?* ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more *If current daily smoker, how soon after you wake?* ☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min *If current daily smoker, are you interested in quitting?* ☐ Ready to Quit ☐ Thinking About Quitting ☐ Not Ready to Quit
Alcohol Use Screening:	Did you have a drink containing alcohol in the past year? ☐ No ☐ Yes *If yes, how often did you have a drink containing alcohol in the past year?* ☐ Monthly or Less ☐ 2-4 Times a Month ☐ 2-3 Times Per Week ☐ 4 or More Times a Week *If yes, how many drinks did you have on a typical day when you were drinking in the past year?* ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more *If yes, how often did you have six or more drinks on one occasion in the past year?* ☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily
Caffeine:	☐ No ☐ Yes - How much? _____ How often? _____
Guns (Optional):	Do you have guns in your home? ☐ No ☐ Yes
Abuse:	History of physical, mental or sexual abuse? ☐ No ☐ Yes
Special Considerations (Notes):	Any other special considerations pertaining to medical care? ☐ No ☐ Yes If yes, explain _____

MORRIS HOSPITAL
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Morris, IL 60450
www.morrishospital.org
People You Know. Extraordinary Care.

Patient Health Questionnaire (PHQ-9)

To be completed if 18 or older

Name: _____ Date: _____

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

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

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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Patient Health Questionnaire (PHQ-9)

How to Score the PHQ-9

Major depressive disorder (MDD) is suggested if:

- Of the 9 items, 5 or more are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

Other depressive syndrome is suggested if:

- Of the 9 items, between 2 to 4 are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores		
Score	Depression Severity	Action
0 - 4	None-minimal	Patient may not need depression treatment.
5 - 9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10 - 14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15 - 19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20 - 27	Severe	Treat using antidepressants with or without psychotherapy.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of 'very difficult' or 'extremely difficult' suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Note: Depression should not be diagnosed or excluded solely on the basis of a PHQ-9 score. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression.[1] Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Reference: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.