Sonora Family Practice

_____	_____	□Female	_____
PRINT PATIENT NAME	PT DOB	□ Male	MRN

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, commonly referred to as an Annual Physical.

Please know that your insurance may limit the reimbursement for this service to once every 365 days. If you have received this service from another provider within the past 365 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age appropriate history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs and radiology services to identify potential problems.

The Annual Preventative Medicine visit does not include the services below. **If you require these additional services today, please be aware your insurance has a separate billing category for which your provider may charge your insurance.** Alternatively, please let your provider know if you do not want these services.

- Evaluation and Management of new or ongoing problems requiring further workup or discussion. This may include a more extensive problem focused physical exam, ordering of diagnostic tests for known problems, prescription drug management, coordinating care with another specialist, or simply providing further counseling related to a chronic diagnosis.

If you have any questions regarding this information, please see the front desk staff.

I have received and read this information.

_____	_____
PATIENT SIGNATURE	DATE

Sonora Family Practice

PRINT PATIENT NAME	PT DOB	□Female □ Male	MRN
_____	_____		_____

Patient Health Questionnaire

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 of 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	0	1	2	3
10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

OVER 

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_____	_____	□Female	_____
PRINT PATIENT NAME	PT DOB	□ Male	MRN

CRAFFT Screening

Please answer all questions honestly; your answers will be kept confidential.

During the PAST 12 MONTHS, did you:	**NO**	**YES**
1. Drink any alcohol (more than a few sips)?	❑	❑
2. Smoke any marijuana or hashish?	❑	❑
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	❑	❑
If you answered YES to any of the above questions please answer the following questions:	**NO**	**YES**
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	❑	❑
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	❑	❑
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	❑	❑
4. Do you ever FORGET things you did while using alcohol or drugs?	❑	❑
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	❑	❑
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	❑	❑

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