Idaho Falls Arthritis Clinic
2220 East 25th Street, Idaho Falls ID 83404
Phone: 208-542-9080 Fax: 208-542-9081

New Patient Intake Form

Thank you for selecting our office for your rheumatological care. We are looking forward to serving you.

We have you scheduled for _____@_____ for a new patient evaluation.
Please fill out the enclosed forms.

Name: _____
Last First Middle

Demographics Race *(Please circle at least one)*:

American Indian or Alaska Native | Asian | Black or African American

Native Hawaiian or Pacific Islander | White | Other Race | Patient Decline

Ethnicity *(Please circle at least one)*:

Hispanic, Latino, or Spanish Origin | Non-Hispanic, Latino, or Spanish Origin | Patient Declined

Address:

_____
City State Zip

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Social Security #: _____

Marital Status: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Referring Physician's Name: _____ Primary Care Physician: _____

Primary Insurance Company: _____

_____
Policy Holder's Name SSN # Date of Birth Relationship

Primary Insurance Company: _____

_____
Policy Holder's Name SSN # Date of Birth Relationship

IDAHO FALLS ARTHRITIS CLINIC
an Affiliate of Mountain View Hospital

AN AFFILIATE OF MOUNTAIN VIEW HOSPITAL

HIPAA Authorization to Disclose Protected Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability And Accountability Act of 1996 {HIPAA) Privacy Standards.

Patient Name:_____ **Patient Date of Birth:** _____

My Authorization

I authorize the following individual or medical practice: _____

To use or disclose the health information indicated below with the following individual or medical practice:

_____

Health Information to be used or disclosed: (Check one)

- ☐ All of patients health information
- ☐ Health information covering dates from_____to _____
- ☐ Health information relating to following treatment or condition:

  _____
- ☐ Other:_____

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I understand that I can receive a copy of this authorization after I have signed it at any time I request a copy.

Signature of Patient_____Date:_____Time: _____

Name of Witness:_____Title: _____

Signature of Witness_____Date:_____Time:_____

Patient Sticker
Last_____
First_____
DOB_____
FIN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Idaho Falls Arthritis Clinic, an affiliate of Mountain View Hospital. Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

When you schedule an appointment with Mountain View Hospital or any of its affiliated locations we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 working day hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- A new patient that fails to show or attempts to cancel/reschedule their appointment and has not contacted our office with at least 24 working day hours notice will have their referral rejected by our office.
- An established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 working day hours notice will noted as a "no show" occurrence.
    - **Should 2 no shows, and/or cancellations/reschedules occur with less than 24 working day hours notice, the patient will be dismissed from Idaho Falls Arthritis Clinic.**

As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A "no show" is someone who misses an appointment without canceling it within a 24 hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

Delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is 10 minutes past their appointment time, we may have to reschedule your appointment. **You may contact us during our business hours or leave a message at: 208-542-9080**

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Printed Name of Patient: _____ Date of Birth:_____

Signature of Patient/Guardian:_____Date/Time _____

Relationship to patient: _____

Patient Information Sheet

Name: _____ DOB: _____ Age: _____

What questions/problems brought you in to see a rheumatologist? _____

_____

1. **Current medications list** (Please list **ALL** medications and dosages, ***INCLUDING*** vitamins, aspirin, etc.):

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. **Allergies to medications** (List all negative drug reactions):

_____
_____
_____

3. **Past medical history** (Hospitalization, operations, significant injuries/accidents) Please include dates:

_____
_____
_____

4. **Please check if you have or have had the following**:
   High blood pressure:____ Gout:____ Cancer:____ Thyroid problems:____ Rheumatic heart disease:____

5. **Family History** (Please check if a family member has or had one of the following):

	Father	Mother	Brother	Sister	Grandfather	(P)	(M)	Grandmother	(P)	(M)
Arthritis	_____	_____	_____	_____		_____	_____		_____	_____
Cancer	_____	_____	_____	_____		_____	_____		_____	_____
Gout	_____	_____	_____	_____		_____	_____		_____	_____
Diabetes	_____	_____	_____	_____		_____	_____		_____	_____
Thyroid disease	_____	_____	_____	_____		_____	_____		_____	_____
Psoriasis	_____	_____	_____	_____		_____	_____		_____	_____

6. **Habits**:
   Do you smoke/vape/chew? NO:____ YES:____
   Do you drink alcoholic beverages?
   NO:___ YES:___ if so how, how often? Daily:___ 1-2 per month:___ 1-2 per year:___

7. **Social/Functional History**:
   List who lives with you at home (Family, pets):_____

   _____

   Your occupation(s):_____

Name:_____ Date:_____

General Health:

	Yes	No
Weight Gain		
Weight Loss		
Fever		
Fatigue		
Chills		
Night Sweats		
Hot Flashes		

Ears, Nose, Mouth, Throat:

	Yes	No
Ear Pain		
Nosebleeds		
Hearing Loss		
Hoarseness		
Ringing in Ears		
Sore Throat		
Mouth Sores		
Drainage		
Congestion		
Difficulty Swallowing		
Dental Pain		

Respiratory/Lungs:

	Yes	No
Shortness of Breath		
Asthma		
Sleep Apnea		
Productive Cough		
Non-Productive Cough		
Wheezing		
Blue Discoloration of Skin		
Snoring		
Daytime Drowsiness		

Eyes:

	Yes	No
Eye Pain		
Vision Disturbance		
Dry Eyes		
Watery Eyes		
Eye Swelling		
Itchy Eyes		

Musculoskeletal:

	Yes	No
Back Pain		
Neck Pain		
Joint Swelling/Stiffness/Pain		
Extremity Pain		
Decreased Range of Motion		
Muscle Aches		
Unable to Bear Weight		
Muscle Spasms/Cramps		

Neurological:

	Yes	No
Numbness or Tingling		
Headaches		
Loss of Balance		
Trouble with Speech		
Forgetfulness or Confusion		
Fainting		
Weakness		
Dizziness		
Loss of Consciousness		
Tremors		
Seizures		
Double Vision		

Cardiovascular:

	Yes	No
Chest Pain/Tightness		
Rapid Heartbeat		
Palpitations		
Varicose Veins		
Swelling in Legs/Feet/Ankles		
Painful Breathing While Laying Flat		

GI:

	Yes	No
Black or Bloody Stools		
Abdominal Pain		
Nausea/Vomiting		
Heartburn/Acid		
Constipation		
Loss of Appetite		
Use of Laxatives		
Cramping		
Diarrhea		

GU:

	Yes	No
Frequent Urination		
Urinary Urgency		
Frequent Nighttime Urination		
Painful Urination		
Blood in Urine		
Testicular Pain		
Pelvic Pain		
Abnormal Urine Smell or Color		
Abnormal Menstruation		
Burning		
Menopause		
Pain During Intercourse		
Weak Urinary Stream		
Urinary Retention		
Protein in Urine		
Incontinence		

Integumentary:

	Yes	No
Rash		
Change in Skin Color		
Itching		
Lesions		
Breast Pain, Lump, or Discharge		
Changes in Moles		
Dry Skin/Nails		

Psych/Social

	Yes	No
Hallucinations		
Behavioral Changes		
Depression		
Suicidal Ideations		
Self-Harm		

Hematological/Lymph:

	Yes	No
Bleeding Easily		
Swollen Glands		
Delayed Healing		
Bruising		

Endocrine:

	Yes	No
Decreased Appetite		
Increased Appetite		
Heat/Cold Intolerance		
Increased Thirst		
Increased Sweating		

Allergy/Immunologic:

	Yes	No
Food Allergy		
Environmental Allergy		
Medication Allergy		
Hay Fever		
Hives		
Immune Disorders		

Patient Health Questionnaire

Please provide a current medical and allergy list when returning your paperwork to the receptionist. If you do not have one, please let the receptionist know. Thank you!

How often have you experience one of the following symptoms over the past two weeks? Please check the option that best describes you.

Little interest or pleasure in daily activities within the last 2 weeks?

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks?

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

If you have answered "Yes" to either of the above questions, please answer the following questions:

Difficulty falling or staying asleep:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Trouble concentrating:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Feeling bad or down about yourself:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Poor appetite or overeating:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Feeling tired or little to no energy:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Moving or speaking slowly:

	No – Not at all
	Yes – More than half the day(s)
	Yes – Several days
	Yes – Nearly every day

Patient Medical Summary

Please answer the following questions related to your medical history:

Do you have an Advanced Directive?

	No
	Yes
	Decline to respond

If so, what type of Advanced Directive do you have?

	Living will
	Medical durable power of attorney
	Other

Please list any *new* medical procedures:

_____

_____

Do you smoke?

	Never (less than 100 times in lifetime)
	4 or less cigarettes (less than 1/4 pack)
	5-9 cigarettes (between 1/4 to 1/2 pack)
	10 or more cigarettes (1/2 pack or more)
	Decline tobacco questionnaire
	Other:

For Patients <u>over 65</u>, please answer the following questions

Please select the option that best describes you:
If any, how many falls have you experience within the last year?

	None
	One **without** injury
	One **with** injury
	Two or more **without** injury
	Two or more **with** injury

Do you feel unsteady when standing or walking?

	No
	Yes

Do you have a fear of falling?

	No
	Yes

Functional Assessment

Please answer the following questions concerning mobility and function:

When you wake up in the morning, do you feel stiff and/or sore?

	No
	Yes
	Most of the time
	Some of the time

☐ Stiff ☐ Sore ☐ Both

If yes, about how long does it take until you start feeling better?

	10 – 15 Minutes
	30 Minutes
	45 Minutes
	60 Minutes
	1 – 2 Hours
	Longer than 2 hours

Please select the general locations you experience the majority of your pain:

	Head (Headaches/Migraines)		Wrists(s)		Hip(s)/Pelvic Region
	Neck		Hand(s)		Upper Leg(s)
	Shoulder(s)		Chest		Lower Leg(s)
	Upper Arm(s)		Torso		Knee(s)
	Lower Arm(s)		Upper Back		Ankle(s)
	Elbow(s)		Lower Back		Feet

On a scale of 0 – 10, with ten being unbearable pain, what is the average of your pain in the past 24-48 hours? Please circle the best choice that describes your pain.

0- No Pain 1 2 3 4 5 6 7 8 9 10- Unbearable

Have you had any bad reactions to any of your current medications since your last visit?

	Yes
	No

Have you had any rashes or mouth sores in the last 30 days?

	Yes
	No
	Mouth sores
	Rash

Do you feel rested in the morning?

	Yes
	No

If no, how many times do you wake from your sleep due to pain?

	1 time
	1-2 times
	2 times
	2-3 times
	More than 3 times

When was your last eye exam? Month: _____ Year: _____

Immunization History

COVID 19 Vaccine Status:

	Not Received
	Pfizer Vaccine
	Moderna Vaccine
	Johnson & Johnson Vaccine
	Other

Number of COVID Vaccine Doses:

	1 Dose
	2 Doses
	3 Doses
	Greater than 3 doses

Have you received an influenza vaccine this flu season?

	Yes
	No, but plan to get one
	No, do not plan to get one
	Unknown

If you do not plan to get a flu shot, why not?

	Allergy/Sensitivity to Flu Shot
	Allergy to Egg
	Allergy to Latex
	Bone Marrow Transplant in last 6 months
	Guillan-Barre Syndrome in last 6 months
	Patient/Family refusal, personal preference
	Vaccine not available
	Physician Recommendation

If you are OVER THE AGE OF 65 OR UNDER THE AGE OF 18, have you received a Pneumonia Vaccine?

	Yes, within the past 5 years
	Yes, more than 5 years ago
	Never received
	Unknown

IF YOU ARE OVER THE AGE OF 65 OR UNDER THE AGE OF 18 and have never received a Pneumonia Vaccine, why not?

	Bone marrow transplant within last 12 months
	Chemotherapy within past 2 weeks
	Currently on scheduled course of chemotherapy
	Currently on scheduled course of radiation
	Radiation within the past 2 weeks
	Other vaccine received in the last 8 weeks
	Shingles vaccine in the past 4 weeks
	Patient/Family refusal, personal preference
	Vaccine not available
	Physician recommendation

RAPID3

[ROUTINE ASSESSMENT OF PATIENT INDEX DATA]

The RAPID3 includes a subset of core variables found in the Multi-Dimensional HAQ (MDHAQ). This portion of the MDHAQ includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3).

RAPID3 scores are quickly tallied by adding subsets of the MDHAQ as follows:

1. Please check the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	without ANY difficulty	with SOME difficulty	with MUCH difficulty	UNABLE to do
a. Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles or three kilometers, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in recreational activities and sports as you would like, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good night's sleep?	☐ 0	☐ 1	☐ 2	☐ 3
l. Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN — PAIN AS BAD AS IT COULD BE

○ 0 ○ 0.5 ○ 1.0 ○ 1.5 ○ 2.0 ○ 2.5 ○ 3.0 ○ 3.5 ○ 4.0 ○ 4.5 ○ 5.0 ○ 5.5 ○ 6.0 ○ 6.5 ○ 7.0 ○ 7.5 ○ 8.0 ○ 8.5 ○ 9.0 ○ 9.5 ○ 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

NO PAIN — PAIN AS BAD AS IT COULD BE

○ 0 ○ 0.5 ○ 1.0 ○ 1.5 ○ 2.0 ○ 2.5 ○ 3.0 ○ 3.5 ○ 4.0 ○ 4.5 ○ 5.0 ○ 5.5 ○ 6.0 ○ 6.5 ○ 7.0 ○ 7.5 ○ 8.0 ○ 8.5 ○ 9.0 ○ 9.5 ○ 10

FN (1) ☐

1 = 0.3 16 = 5.3
2 = 0.7 17 = 5.7
3 = 1.0 18 = 6.0
4 = 1.3 19 = 6.3
5 = 1.7 20 = 6.7
6 = 2.0 21 = 7.0
7 = 2.3 22 = 7.3
8 = 2.7 23 = 7.7
9 = 3.0 24 = 8.0
10 = 3.3 25 = 8.3
11 = 3.7 26 = 8.7
12 = 4.0 27 = 9.0
13 = 4.3 28 = 9.3
14 = 4.7 29 = 9.7
15 = 5.0 30 = 10.0

PN (2) ☐

PTGE (3) ☐

RAPID3 ☐

Category

HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤ 3

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

Patient Name: _____

Signature: _____ Date: _____

RTC: ☐ Dr. Scoville ☐ Dr. Yu ☐ Jace Nebeker ☐ Eliza Long