Patient Registration

Patient Information

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Jose F.Polanco, MD., P.A.. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Jose F. Polanco, MD., P.A. to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing .

_____ _____

Signature of Patient/Responsible Party Date

_____

Name of Patient/Responsible Party (Please Print)

Patient Registration

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Patient Registration

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Alive	Deceased
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Alive	Deceased
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient			
Occupation		Employer	
How many siblings do you have? None		Sister(s):_____	Brother(s):_____
Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

Statements / Billing

*** As of July 1st, 2019- STATEMENTS will be PAPERLESS! You will now receive it per your PATIENT PORTAL (Healow web-based).**

In order for you to receive your statements online on your patient portal, an email is needed to create your account. You will be able to pay your balance instantly or you have the option to send a check. As well as, each account is linked to that email you have provided us. Unfortunately, there can only be on email per account.

Email

HIPAA
Notice of Privacy Practice

Jose F. Polanco,M.D.,P.A. has a policy of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), our objective is to be 100% compliant at all times. The following method of operation will be used to insure privacy of patients protected health information (PHI).

1. Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization and will not be transferred without your signed authorization.
2. After a review of your records if you disagree with any of the documents in the records, you have the option of writing your own documentation to be placed in the chart.
3. If an appointment with another provider is required, only necessary information will be provided.
4. If you elect to allow any member of your family access to your records, you have the right to notify our office. That notice must be be in writing. If you wish to provide access to our records to a designated individual, you may also provided that in writing.
5. Our office will not provide any information about you or your medical condition to any other party other than medical providers to whom you have been referred to for treatment without your specific consent.
6. If you are chosen to be a part of any research program, you will be required to sign additional authorization and releases so that your PHI may be used in the program.
7. Under HIPAA rules, we may use necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignments allow the practice to file insurance claims on your behalf.
8. There will be certain circumstances where public health authorities may require a copy of your medical records. They are authorized under law to collect that information and we are required to furnish that information, a copy of your PHI. You may review your records at a schedule time with our office.
9. All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons.
10. If you are on active military duty or called to active duty military, under federal law we are required to supply a copy of your records.

If you should have any questions concerning any of the above please feel free to contact any of that staff of Jose F. Polanco,M.D.,P.A.

Signature:_____ Date: _____

REFERRAL PROCESS: All **non -urgent referrals** require a **waiting period of 5-10 working days** in order to be processed. All **Urgent referrals** require **48 hours** to be processed. Emergency referrals will be processed within the **same day**. We will fax the referral on your behalf to the appropriate facility and provided with the needed information for you to complete your care. On some occasions this may require for us to leave a message on your answering service. Therefore, it is not only important- but **your responsibility**- to maintain your contact information up to date with our office. In specific circumstances and to assure the best quality care possible for the patient, we use a preferred network of physicians. A list of the physicians will be provided to you upon your request.

Initial: _____

Visits: Every patient is expected to be seen **minimally twice a year** for a **complete review and assessment of all medical problems**. If you are a patient with a specific problem(s) - such as a chronic disease- you may require more frequent visits to better manage your health: **your compliance is crucial and expected.** By all means, please take advantage of this opportunity and indicate any necessary medication refills, visits made to the specialist(s) since your prior visit to ur office, emergency room visit(s) or hospital stay(s).

Initial: _____

Preventative Care: You will be asked on multiple occasions to comply with preventative screenings that must be completed each calendar year. These screenings include the following:

1. Labs- every 6 months some conditions require more frequently
2. Annual Mammogram- females only
3. Colonoscopy- every 3-10 years based on your need
4. Stool Card- for patients 50 years or older
5. Annual Eye Exam

If it has been less than a year that you had any of the above mentioned screenings done with your prior medical care provider, please, obtain a copy of these records or inform the front-desk so that we may quest them on your behalf. We will work tirelessly and do all within our means to improve your health with every visit that you make to our office. If you have any non-clinical concerns, at any time, please request to speak with the office administrator. Thank you for choosing Jose F. Polanco,M.D.,P.A.

Initial: _____

Injury Medicine Notice

_____ _____

Informed Consent For Purpose of Treatment,Payment, and Healthcare Operations

I,_____ consent to the use or disclosure of my protected health information by **Jose F. Polanco,M.D.,P.A.** for the purpose of diagnosis or providing treatment to me after explanation of the risks and benefits of such treatment, obtaining payment for my healthcare bills and/ or to conduct healthcare operations. I understand that diagnosis/ treatment of me by **Jose F. Polanco,M.D.,P.A** may be conditioned upon my consent as evidenced by my signature on this document.

I Understand thatI have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment(s), payment or healthcare operations of the practice (Please list all restrictions in the provided area below). **Jose F. Polanco, M.D.,P.A.** is not required to agree with the restrictions that I may request. However, v agrees to a restriction that I request, the restriction is binding on **Jose F. Polanco,M.D.,P.A**.. I have the right to revoke this in writing at any time, except to the extent that **Jose F. Polanco, M.D.,P.A** has taken action in reliance on this consent.

My "Protected health information" (PHI) means health information, including my demographic information collected from me and created or received by my physician,another health care provider, a health plan, my employer, or a health clearinghouse. The protected health information related to my past, present, or future physical mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review **Jose F. Polanco,M.D.,P.A.** Notice of Privacy practices prior to signing this document. **Jose F. Polanco,M.D.,P.A.** Notice of Privacy is posted in a public location and is available to all patients. I Understand that I may obtain a copy of the Notice of Privacy Practice upon request. The Notice of Privacy Practice describes the types of disclosures of my PHI that will occur in my treatment, payment of my bills, and. Or in the performance of health care operation fo v duties with respect to my protected health information. **Jose F. Polanco,M.D.,P.A.** reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practice. I may obtain a revised of Privacy Practice by calling the office and requesting a revised copy be sent in the mail on my below listed address or asking for one at the time of my next appointment.

List all request restrictions (i.e."do not release my information to any family members")

_____

_____

List any family members or others that are allowed to have access to your information
(i.e.spouse,child,caregiver)

_____

_____

Doctors Response:_____

Doctors Signature & Date: _____

Signature of Patient_____

Patient Address _____

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. We may communicate with you through mail and telephone, including leaving messages on your answering machine/voice mail.

Please check all boxes that you give Dr.Jose Polanco permission to use for your communications:

□ You may contact me by telephone Phone Number:_____ □ You may leave a message/voice mail Phone Number:_____
□ You may contact me Healow

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		□ Billing Information □ Appointment Information □ Medical/Health Information
2.		□ Billing Information □ Appointment Information □ Medical/Health Information

Because our office is now paperless, this means you will able to see your medical records via Healow (Phone App) or on the desktop (Patient Portal). Patients are able to utilize the portal to accomplish tasks that would normally require a phone call, or even multiple calls this will allow us to have a faster response.This ability for patients to request / cancel appointments, referrals, billing questions and prescription refills directly from the patient portal increases the efficiency of our clinical staff, allowing them to keep their focus on assisting you with the patients who have the most urgent care needs and questions. Please don't hesitate to call us.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____

Name of Patient/Responsible Party (please print)

Open Balance Policy

Any open balance 30 days old will have to be paid in full or partially before you can be seen by Dr. Polanco.There will be only **one** exception, if you are on a payment plan and compliant. Below you will find a listing of the portion of the balance that you would have to pay off before being seen.

If You Owe:	You Pay:
$0.01--$75.00	100%
$76.00--$100.00	75%
$101.00--$150.00	50%
$151.00--$200.00	50%
$201.00--$300.00	40%
$301.00--$400.00	40%
$401.00--$500.00	30%
$501.00--$600.00	30%
$601.00--$700.00	30%
$701.00--$1,000.00	25%
$1,001.00- and up!	10%

Please, sign and date on the acknowledge that you have read this. Thank you.

Patient Signature: _____ Date: _____

Cancellation / No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't call to cancel an appointment you are preventing another patient from getting much needed treatment. Please make sure when you call to cancel an appointment it it at least 24 hours in advance. If the appointment is not cancelled you will be charge **$50.00 fee** that will not be covered by your insurance company.

Please, sign and date on the acknowledge that you have read this. Thank you.

Patient Signature: _____

Date:_____

FUNCTION STATUS & PAIN ASSESSMENT

Patient: Date:

Date of Birth: Physician: Jose F. Polanco

1. Do you need assistance to walk? Yes No (if yes, do you utilize any of the following?)

   Walker Cane Wheelchair Powerchair Prosthetics

2. Do you wear any of the following? Yes No

   Glasses Contacts Hearing Aids Dentures Monocles

3. Do you have speech problems? Yes or No (if yes, please state): _____

   Yes No

4. Are you able to exercise? Yes or No (if no, please why):_____

5. Do you have any Advance Directive? Yes or No (if yes, please bring a copy in your next visit)

   Yes No

6. Do you have ongoing pain? Yes No Level of pain (10 being the worst)

   Location:_____ 1 2 3 4 5 6 7 8 9 10

Have you ever had performed any of these test? Yes or No (if yes, please state Month & Year)

Female Only	Male Only
Mammogram: Month_____Year_____	Prostate Exam: Month_____Year_____
Bone Density: Month_____Year_____	
Pap Smear: Month_____Year_____	

Have you ever had any of the following tests/ vaccinations? (On what approximate Month & Year)

Colonoscopy: Month_____Year_____
Endoscopy: Month_____Year_____
Stool Test: Month_____Year_____
Visual Exam: Month_____Year_____
Chest X-Ray: Month_____Year_____

Shingles Vaccine: Month_____Year_____
Tetanus Vaccine: Month_____Year_____
Pneumonia Vaccine: Month_____Year_____
Flu Vaccine: Month _____ Year_____

Smoking & Illicit Drugs

1. Are you a smoker? Yes or No What Type: _____ How many per week:_____

   Yes No

2. Are you a former smoker? Yes or No How long ago did you quit? _____ Never Smoked _____

   Yes No

3. Do you drink alcohol? Yes or No (if yes, state how much): _____ How many times per Month?_____

   Yes No

4. Do you use any illicit drugs? (if yes,name):_____ How often used? _____

*Attention: anyone who takes controlled medication(s) will be referred to the specialists. We will no longer provide Pain or Psych medications starting January 1st,2018.

Care of Adult (COA)

Do you require assistance with any of the following?

1.Ambulation:

Independent Require Assistance Walker Cane Wheelchair Prosthetic Powerchair

Other:_____

2.Gait: Balanced Inbalanced Using assistance Without assistance

3.Proprioception (motor skills):

Intact Risk of Falls (if yes why?):_____

A) In the past 12 months how many times have you fallen and why?_____

B) Did you injure yourself after falling?_____

4.Physical activity in the home such as cooking/cleaning? Active Inactive

5.Physical activity outside the home such as buying groceries? Active Inactive

6.Bathing: Independent Require Assistance Handle Bench Family Member Seat Personal Assistance

7.Dressing: Independent Require Assistance Family Member Personal Assistance

8.Toileting: Independent Require Assistance Walker Cane Rails Family Member Personal Assistance

9.Transferring (moving from place to place): Independent Require Assistance Walker Cane Rails Family Member Personal Assistance

10.Continence: Independent Require Assistance Walker Cane Rails Family Member Personal Assistance

A) Have you leaked urine without physical activity or urge? Yes No

B) Have you leaked urine while doing physical activities such as sneezing,lifting,coughing? Yes No

C) Have you leaked urine when you had the urge and couldn't get to the restroom on time? Yes No

11.Feeding: Independent Require Assistance, please explain:

12.Cognition (mental status): Intact Impaired, please explain condition:

13.Do you require assistance taking medications? if yes, please explain:_____

Yes No

14. Have you ever had a bone fracture? if yes, where?: _____

Yes No

15.Do you have have any new or persistent allergies reactions? Yes or No (if yes to what?):_____

Yes No A) What kind of reaction do you get?

16.How many times have you visited the E.R. in the past 12 months?:_____

Why?:_____

_____

Patient Name:_____ Date: _____

List Current Doctors/Specialists

_____ _____

_____ _____

1. When did you last have any of the following test done? Please provide the (Month, Year and Place).

Chest X-Ray:_____

MRI/MRA: _____

CT scan / Angiogram: _____

Ultrasound: _____

Vascular Ultrasound: _____

X-rays: _____

Nuclear Medicine: _____

Most Recent Blood Work: _____

Echocardiogram: _____

Spirometry: _____

Other: _____

Visual Exam:_____

2. Have you ever been Diagnosed with any of the following?

A. Diabetes Mellitus
B. Atrial Fibrillation
C. Asthma / COPD
D. Hepatitis
E. HIV / AIDS
F. Alzheimers/ Dementia
G. Anxiety/ Depression
H. Mental Disorder
I. Heart Failure
J. Kidney/ Liver Disease
K. Osteoporosis
L. Other: _____

3. Have you had any recent surgeries? If yes, please specify:

A._____ Month _____ Year _____
B._____ Month _____ Year _____
C._____ Month _____ Year _____

Please list all current medications.

A. _____ D. _____
B. _____ E. _____
C. _____ F. _____

Patient Name: _____ Date: _____

Revised 01/2018

José F. Polanco, M.D., P.A.

Patient Health Questionaire-9

(PHQ-9)

Name: _____ **Date:** _____

Please answer the following questions to the best of your ability.
Over the last 2 weeks, how often have you been bother by any of the following?

Question	Not at all	Some days	Several days	Nearly every day
1. Little interest or no desire of doing things?	0	1	2	3
2. Feeling down, depressed or hopeless?	0	1	2	3
3. Trouble falling and or staying asleep. Sleeping too long?	0	1	2	3
4. Feel tired or with poor energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feel bad about yourself, like a failure or that you have let yourself or family down?	0	1	2	3
7. Trouble concentrating or performing a task?	0	1	2	3
8.Have you been moving slow or speaking slower than usual? Or feeling fidgety or restless?	0	1	2	3
9. Thought of suicide or hurting yourself in some way?	0	1	2	3

Total Score: _____

- **If you have checked off Any problems, please circle the impact these problems made your daily life style and dealing with the public?**

Not difficult **Somewhat difficult** **Very Difficult** **Extremely difficult**

Once your form is completed please email it to info@polancomd.com and call us after at 941-708-3358 to make sure we have received the form. Thank you!