Camillus Health Concern, Inc.
PSYCHOSOCIAL REPORT

I. Date _____ CHC Number _____

Client Name _____ _____ _____
Last First SSN

II. Name Children(s) Age Sex Birth Dates

a. _____ ____ ____ _____

b. _____ ____ ____ _____

c. _____ ____ ____ _____

d. _____ ____ ____ _____

III. Family/Friends/Agency Contacts
(name, relationship, address, telephone number)

a. _____

b. _____

c. _____

IV. Presenting Concern(s) _____

V. Living Situation _____

_____

VI. Income and Expenses _____

_____

VII. Family History _____

_____

_____

VIII. Homelessness History _____

_____

_____

IX. Employment History _____

_____

_____

CHC Number _____

Client Name _____ _____ _____
Last First SSN

X. Addiction History _____

XI. Mental Health History _____

XII. Medical History _____

XIII. Other Background Information _____

XIV. Impressions _____

CHC Number _____

Client Name _____ _____ _____
Last First SSN

XV. Problems

a. _____

b. _____

c. _____

d. _____

Community or Camillus House Referrals

a. _____

b. _____

c. _____

d. _____

XVI. Follow-up Plan _____

_____

_____

Signature: _____

Print Last Name: _____

Title: _____

Approved: 03/06/96 ; Revised: 10/98; Printed: 10/9/98
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Camillus Health Concern, Inc.
Financial Assessment/Sliding fee Assignment

Date: _____ Medical Record #_____

Patient's or Patient's/Guardian's Self Reporting of Income

Name:_____
Last Name First Name DOB

Individual/Family Income (Gross): $_____ ☐ weekly ☐ monthly ☐ annually

Family Size (including yourself): _____

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4._____

Source of Income:

☐ Employment ☐ Unemployed ☐ VA Benefits ☐ Social Security Retirement Disability

☐ Supplemental Security Retirement Income ☐ Supplemental Security Retirement Disability

☐ Wages ☐ Other ☐ If unemployed, date last employed: _____

Patient's or Patient's/Guardian's Consent

I have read this assessment (or had it read to me) in a language that I understand.

I authorize investigation of all statements contained in this assessment. I understand that misrepresentation or omission of facts is cause for my assessment to be assigned to Full Pay category.

I understand that if there are patient fees for services received at Camillus Health Concern, Inc., they are my responsibility.

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Staff Signature (Witness) Date

Camillus Health Concern, Inc
Registration Form

CHC Medical Record # _____

1. Last name: _____ Middle initial: _____
2. First name: _____ Phone number: _____
3. Address: _____ Zip Code: _____
4. Emergency contact: _____ Phone number: _____
5. Relationship to emergency contact: _____
6. Social Security: _____-_____-_____
7. Country of birth: _____
8. Date of birth: _____/_____/_____ ❑ Female ❑ Male
9. Marital status: _____
10. Nationality: (*Please choose one*)

    ❑ Asian ❑ Black (*Non-Hispanic*) ❑ Hispanic (*All Races*) ❑ White

    ❑ Indian/Alaskan Native ❑ Pacific Islander ❑ Unknown ❑ Other _____
11. Preferred Language _____
12. Are you employed: ❑ Yes ❑ No If yes weekly income $ _____
13. How many people are supported by this income (*including yourself*) _____
14. What type of insurance do you have? (*Please choose one*)

    ❑ Medicaid ❑ Medicare ❑ Medipass ❑ Physicians Healthcare Plan ❑ Not apply
15. Mother's first name: _____
16. Mother's birth last name: _____
17. Father's first name: _____
18. Father's last name: _____
19. Living Situation (*Please choose one*)

    ❑ Street ❑ Hotel/Motel

    ❑ Car ❑ Substance Abuse/Treatment Center

    ❑ Shelter ❑ Apt/House (*less then 12 months*)

    ❑ Transitional Housing ❑ Apt/House (*more than 12 months*)

Staff Initials: _____

CAMILLUS HEALTH CONCERN, INC.

Please complete so that we have the most updated information on you.

Name:_____

Address:_____

TelephoneNumber:Home_____Work_____

Check one of the following:

Do you have Medicaid or Medicare? ____ Yes ____ No

Do you get a check every month? ____ Yes ____ No

Thank You

Por favor complete, para que nosotros tengamos la mas reciente informacion de usted.

Nombre :_____

Direccion:_____

Numero de Telefono:-Casa_____ Trabajo _____

Marque uno de los Siguiente:

Usted tiene Medicaid o Medicare? _____ Yes _____ No

Usted recibe un cheque cada Mes? _____ Yes _____ No

GRACIAS

CAMILLUS HEALTH CONCERN, INC
PATIENT GRIEVANCES

POLICY NUMBER: MP-07 **REVISION DATE: 03/26/02**

I. POLICY

Camillus Health Concern, Inc (CHC) is committed to provide quality care to all its consumers. As we strive for "Excellence in Care", we recognize that at times there may be occasions when consumers find themselves involved in circumstances or conditions believed to be unjust, and thus that they have grounds for a grievance. Therefore, it is the policy of CHC to acknowledge consumer rights and provide an impartial and confidential forum for the resolution of any grievance that may be brought to the attention of staff at CHC.

II. Grievance Committee Membership

A. The Grievance Committee (thereinafter "Committee") will be a Standing Committee consisting of three (3) persons, who will meet on an ad hoc basis. That is, the Committee will meet, if and when a grievance is filed.

B. Representing a cross section of disciplines and backgrounds, the membership of the Committee will be comprised of:

- One (1) Brother representative from the Brothers of the Good Shepherd, who is staffed at Camillus
- One (1) CHC Management staff representative
- One (1) CHC Patient Services staff representative
- If necessary, the consumer's health care provider and/or case manager will be invited to attend the Grievance Committee meeting.

C. Membership length will be approximately one (1) year and will be staggered to allow for continuity within the Committee. The Committee Chair, who will be elected by the Committee, will provide oversight to ensure that there is continuity and that the Committee is fully staffed. As needed, the Chair will make recommendations for new members to the Executive Director.

III. PROCEDURES

A. Every effort will be made to amicably resolve a complaint before it becomes a formal grievance; however, if the consumer declines to speak with a CHC staff member in order to resolve the compliant, he or she has the right to file a formal grievance.

B. A consumer who verbalizes his or her dissatisfaction with, for example, a service, procedure, employee, or physical appearance of the facility, will be encouraged to resolve the issue by dialogue with the appropriate staff member (the immediate supervisor of the area or discipline covering the grievance). The consumer will do this by verbalizing in private to that supervisor his or her dissatisfaction.

C. If the complaint is against the immediate supervisor of the area or discipline, than the supervisor will consult with his or her supervisor as to who should address the complaint.

D. Immediately upon being informed of the dissatisfaction, the supervisor will inform the consumer of the method he or she will use to attempt to resolve the issue. If the supervisor cannot immediately resolve the issue to the satisfaction of the party involved, he or she will follow-up with the consumer within 24 hours, with additional steps in order to resolve the issue.

E. In the event that the issue cannot be resolved, the consumer may file a formal grievance with the supervisor who has been assisting him or her. As needed, the supervisor will assist the consumer in completing the form and ensure that the form has been completed accurately. See attachment 1 for the Camillus Health Concern, Inc. Grievance Form.

F. The supervisor will provide a copy of the Grievance Form to the consumer, and the original is then forwarded to the Chair of the Committee.

G. The Chair then sends a copy of the Grievance Form to the Camillus House Chief Executive Officer and CHC's Executive Director so that they may become aware of possible safety, legal, or other issues. However, the grievance continues to be processed by the Chair of the Committee.

H. Within five (5) working days, the consumer will be notified, in writing, of the receipt of the grievance and the scheduled date for review by the Committee.

I. Prior to the meeting, the Chair will forward a copy of the Grievance Form to all Committee members.

J. Also, prior to the meeting, the Chair may use his or her discretion to initiate a preliminary investigation of the grievance. For example, in order to facilitate the Committee's first meeting, the Chair may decide to conduct some interviews prior to the meeting.

K. The Chair will maintain all grievance materials and documents, for example, the Grievance Policy and Procedures and meeting minutes, in the Camillus Health Concern Grievance Documents binder.

III. Grievance Review Process

A. The Committee will make a good faith effort to convene within two (2) weeks of when a grievance is filed and schedule additional meetings, at least every two (2) weeks, until recommendations for the resolution of the grievance are finalized.

B. The Committee will determine if additional persons need to be interviewed as part of its impartial investigation.

C. Additional interviews and/or investigation by Committee Members must be written and submitted to the entire Committee for its review at a scheduled meeting.

D. The Committee's recommendations for action, including timelines, will be prepared and presented by the Chair of the Committee to the Executive Director, who will then either approve the recommendations as presented, or modify them, and then, finally, approve the recommendations. See Attachment 2, Camillus Health Concern, Inc. Grievance Committee Recommendations for Action.

E. After the Executive Director approves the recommendations, the consumer will be so notified in writing within ten (10) working days.

F. If the grievance is not resolved at the Committee level, the Committee Chair will confer with an Ad Hoc Committee of the Board of Directors, chosen by the Chairperson of the Board. The Ad Hoc Committee of the Board will review the grievance and recommend to the Board to uphold or to refute the resolution.

G. The consumer will thereafter be so advised of the final resolution of the grievance.

V. Quality Improvement

A. The Chair of the Committee will submit summaries of grievances to CHC's Quality Improvement Committee (QIC) for trending and monitoring of the grievances.

B. The QIC will ensure that all Committee recommendations are implemented, and kept confidential.

DATE: _____ **CHC WOMEN'S HEALTH CLINIC** CHC# _____

NAME: _____ AGE: _____ DOB: _____ ALLERGIES: _____

FDLMP_____ X _____ Days

MENOPAUSE/AGE _____ ERT: NO ___ RES: _____yrs.

G _____ PARA: F _____ P_____ A_____ L_____ SEXUALLY ACTIVE NO YES

Birth Control: None OCP Diaphragm IUD Condoms Other_____

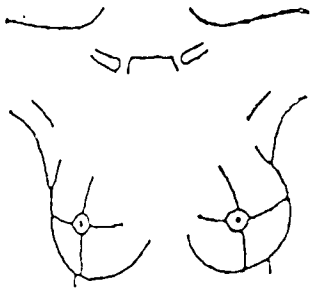
Last PAP: _____ Last MAMMOG _____

F.H. BREAST CA: NO YES: MOTHER SIB AUNT MSBE: NO YES

PMH/STD: MEDS: ETOH: NO / YES
TOB: NO / YES
IVDU: NO / YES
HOMELESS: NO / YES

BS: BP _____ HR_____ R _____ T _____ HT _____ WT _____

BREAST:



PELVIC: EXT.
Vaginal
Cervix

BIMANUAL: CMT: NEG / POS
Adnexa:
Uterus:

KOH
Wet Mount
GM Stain
UCG - +

ASSESSMENT / PLAN:

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 1 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula WIC yes ☐ no ☐
Stools Urine: Sleep: Sleep arrangements:

Growth & Development
_____Raises head slightly _____Responds to sound
_____Has tight grasp _____Fixes on face
_____Follows objects to midline _____May smile

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Vitamins, flouride 0.25 mg q.d.
_____ Delay solids
_____ Feeding/ Spitting up

Health
_____ Hiccups/ Sneezing/ URI
_____ Irregular respirations
_____ Rashes

Safety
_____ Fire retardant clothing
_____ Car seats
_____ Smoke detector
_____ Crib safety/ falls

Psychosocial
_____ Pacifier/ crying/ colic
_____ Hold, cuddle
_____ Talk to baby
_____ Vision/ colors
_____ Attention to other children

Assessment/Plan:

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 2 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula WIC yes ☐ no ☐
Stools Urine: Sleep: Sleep Arrangements:

Growth & Development
_____Holds head in middle
_____Lifts head and chest
_____Follows objects 180°
_____Coos, laughs, locates sound
_____Social smile

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17: Other:		

Anticipatory Guidance

Nutrition
_____ Vitamins, flouride 0.25 mg q.d.
_____ Delay solids
_____ Bottles in bed

Health
_____ Infant tylenol gtt
_____ Hiccups/ Sneezing/URI
_____ Irregular respirations
_____ Rashes

Safety
_____ Rolling/falling
_____ Toys
_____ Car seat
_____ Burns/Hot liquids
_____ Crib safety

Psychosocial
_____ Pacifier/crying/ colic/spoiling
_____ Hold/cuddle/play
_____ Talk to baby
_____ Vision/colors
_____ Attention to other children

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Smiles spontaneously
_____Begins reaching
_____Hands together
_____Moves arms to grasp
_____Head steady
_____Rolls front and back
_____Laughs out loud

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		

Anticipatory Guidance

Nutrition
_____ Flouride suppl.
_____ ? cereals with spoon delay other solids

Health
_____ Teething
_____ Respiratory infections
_____ Vomiting/ Diarrhea
_____ Thumbsucking

Safety
_____ Aspirations
_____ Toys
_____ Car seat
_____ Discourage walker
_____ Falls/Burns

Psychosocial
_____ Spoiling
_____ Interaction with other siblings
_____ Talking to baby

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula
Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Reaches & transfers
_____Rolls back to front
_____Sits with support
_____Turns to sound
_____Reacts to strangers
_____Lifts cup, holds bottle
_____Weight bearing
_____No head lag
_____Babbles/Laughs

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Cereals, fruits, veg.
_____ Use of spoon and cup

Health
_____ Teething
_____ No bottles in bed
_____ Head injury
_____ URI
_____ Thumbsucking

Safety
_____ Protect from hot liquids, dangling cords, tablecloth
_____ Water & Bathtub safety
_____ Car seat
_____ Poisoning/ Ipecac
_____ Soft shoes
_____ Use gates on stairs

Psychosocial
_____ Stimulate speech
_____ Separation anxiety

Assessment/Plan:

Screen: Hgb_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 9 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula Solids

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Creeps, Crawls, cruises
_____Pulls to stand
_____Uses pincher grasp
_____Finger feeds
_____Sits well
_____Understands no & bye bye
_____Retrieves hidden toy
_____Starts to explore
_____"Dada/Mama" nonspecifically

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
Health
Safety

_____ Pica
_____ Dental care
_____ Water safety
_____ Babyproofing the house
_____ Poison/ burns
_____ Aspiration
_____ Toddler car seat if wt. 20 lbs.

Psychosocial

_____ Use of "no"
_____ Discipline consistency
_____ Masturbation
_____ Breath holding spells
_____ Social games
_____ Night wakening
_____ Favorite toy or possession
stairs
_____ Stimulate speech

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 12 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula Solids
Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Walks with support/alone
_____Throws object
_____Uses mature pincher grasp
_____Makes 1-3 words or meaningful sound
_____Gives hug
_____Dada/Mama specifically

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
. Other:		

Anticipatory Guidance

Nutrition
_____ Table foods
_____ Drop in appetite
_____ Off bottle
_____ Regular milk

Health
_____ Tylenol
_____ Respiratory infections

Safety
_____ Hot liquids
_____ Use of "no"
_____ Kitchen, stair, water & car safety
_____ Fences, gates, latches
_____ Poisoning, Ipecac

Psychosocial
_____ Bedtime stories/ books
_____ Delay toilet training
_____ Discipline
_____ Favorite toy possession
_____ Stimulate speech

Assessment/Plan:

Screen: Hgb_____
Lead_____
Sickle cell_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 15 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night
_____Naps per day

Growth & Development

_____Builds tower of 2 blocks
_____Uses 3 to 6 words
_____Understands simple commands
_____Creeps upstairs

_____Walks well
_____Feeds self with fingers
_____Points to 1 or 2 body parts

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Utensil use
_____ Diet, snacks
_____ Wean off bottle
_____ Drop of appetite

Health
_____ Dental care
_____ Respiratory infections

Safety
_____ Hot liquids
_____ Kitchen, stair, water & car safety
_____ Fences, gates, latches
_____ Poisoning, Ipecac

Psychosocial
_____ Bedtime stories/ books
_____ Delay toilet training
_____ Discipline
_____ Favorite toy or possession
_____ Stimulate speech
_____ Temper tantrums

Assessment/Plan:

Provider: _____

CAMELLUS HEALTH CONCERN

HEALTH MAINTENANCE ASSESSMENT - 18 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development

_____Uses spoon, feeds self
_____Removes garment
_____Imitates housework
_____Dumps from container

_____4-10 words
_____Pulls toy
_____Stacks 3 to 4 blocks
_____Walks up stairs
_____Kicks/Throws

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Pica/Lead
_____ Diet, snacks
_____ Wean off bottle
_____ Drop of appetite

Health
_____ Dental care
_____ Respiratory infections

Safety
_____ Hot liquids
_____ Kitchen, stair, water & car safety
_____ Fences, gates, latches
_____ Poisoning, Ipecac

Psychosocial
_____ Bedtime stories/ books
_____ Night fears
_____ Temper tantrums
_____ Discipline
_____ Favorite toy or possession
_____ Stimulate speech

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 24 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development

_____Runs well
_____Helps to undress
_____Imitates adults
_____Dumps from container
_____Open doors/climbs

_____20 words
_____Handles spoon well
_____Stacks 5 to 6 blocks
_____Walks up & down stairs
_____Kicks ball/Throws

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____Pica/Lead
_____Diet, snacks
_____Avoid control struggles/eating

Health
_____Dental care
_____Day napping varies

Safety
_____Crib to bed
_____Car seat
_____Matches/ Burns/ Falls/ Water safety
_____Fences, gates, latches
_____Play equipment

Psychosocial
_____Bedtime stories/ books
_____Night fears
_____Temper tantrums
_____Discipline
_____Unable to share
_____Toilet training/ Bedwetting
_____Genital explor.

Assessment/Plan:

Screens: CBC_____
Lead_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 30 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ❑ defer ❑

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development

_____Puts on clothing
_____Washes & dries hands
_____Separates from Mom easily
_____Plays tag
_____Copies O

_____Uses plurals
_____Gives 1st & last name
_____Stacks 8 blocks
_____Jumps in place
_____Balance on 1 foot/1sec.

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Diet
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Crib to bed
_____ Car seat
_____ Matches/ Burns/ Falls/ Water safety
_____ Fences, gates, latches
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Temper tantrums
_____ Discipline
_____ Unable to share
_____ Toilet training/ Bedwetting
_____ Genital explor.

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 3 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ❑ defer ❑

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development

_____Buttons up
_____Dresses with supervision
_____Separates from Mom easily
_____Plays tag
_____Copies O

_____Uses plurals/past tenses
_____Gives 1st & last name
_____Stacks 8 blocks
_____Broad jumps
_____Group play

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Diet
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Street safety
_____ Car seat
_____ Matches/ Burns/ Falls/ Water safety
_____ Fences, gates, latches
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Temper tantrums
_____ Discipline
_____ Pretend play
_____ Group play/sharing
_____ Toilet training/ Bedwetting
_____ Genital explor.

Assessment/Plan:

Screen: Dental referral_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development
_____Buttons up
_____Dresses self
_____Copies +
_____Copies ☐
_____Balances 5 seconds

_____Draws 3 part man
_____Names 3 to 4 colors
_____Counts to 5
_____Hops on 1 foot
_____Catches bounced ball

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
4. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Small portions
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Toxic substances
_____ Bicycle safety
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Pretend play
_____ Group play/sharing
_____ Toilet training/ Bedwetting
_____ Sexual curiosity

Assessment/Plan:

Screen: Dental referral_____
CBC_____
Lead_____
UA_____
Vision_____
Audiometry_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 5 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night

Growth & Development

_____Skips, walks on tiptoe
_____Dresses self
_____Ties shoes
_____10 word sentences
_____Balances 10 seconds

_____Draws 6 part man
_____Prints first name
_____Copies ▲
_____Backward heal/toe walk
_____Catches bounced ball

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Small portions
_____ Healthy snacks

Health
_____ Dental care

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Toxic substances
_____ Bicycle safety
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Dressing up play
_____ Gender Identification
_____ Understands right and wrong

Assessment/Plan:

Screen: Dental referral_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night

Growth & Development

_____Bounces ball 6 times
_____Ties shoelaces
_____Counts to 10
_____Prints name and numbers
_____Grade in school

_____Draws 6 part man with clothes
_____Knows right from left
_____Backward heal/toe walk

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculosketal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Avoid junk food
_____ Healthy snacks
_____ Maintain appropriate wt.

Health
_____ Dental care
_____ Regular exercise

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Learn to swim
_____ Bicycle safety
_____ Limit TV viewing
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Relationship with peers
_____ Communication with Parents/Praise
_____ Rules/Chores

Assessment/Plan:

Screen: Dental referral_____
Cholesterol/Trig
if + family hx_____

Provider:_____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 7-12 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta

_____Fruits, vegetables

_____Milk, yogurt, cheese

_____Meat, poultry, fish, beans

Development:

Grade in school _____ Performance in school _____

Career plan _____ Problems with peers/siblings _____

Favorite Activity

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
a. Tanner stage:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
- _____ Avoid junk food
- _____ Healthy snacks
- _____ Maintain appropriate wt.

Health
- _____ Dental care
- _____ Regular exercise

Safety
- _____ Street safety
- _____ Fire safety
- _____ Matches/ Burns/ Falls/ Water safety
- _____ Learn to swim
- _____ Bicycle safety
- _____ Limit TV viewing
- _____ Gun safety

Psychosocial
- _____ Books/Library card
- _____ Communication with parents
- _____ Alcohol/Drugs/ Smoking
- _____ Sexual development
- _____ Pubertal teaching

Assessment/Plan:

Screen: Dental referral _____
Cholesterol/Trig _____
if + family hx _____
CBC & UA _____
Vision _____
Audiometry _____
PPD _____

Provider: _____

HEALTH M. (ENANCE ASSESSMENT - ADOL. (NT VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta

_____Fruits, vegetables

_____Milk, yogurt, cheese

_____Meat, poultry, fish, beans

Development:

Grade in school _____ Performance in school _____

Career plan _____ Problems with peers/siblings _____

Favorite Activity _____

Drugs _____ Sexual activity _____

Menstrual Hx

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
a. Tanner stage:		
b. Pelvic/pap:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
- ____ Avoid junk food
- ____ Healthy snacks
- ____ Maintain appropriate wt.

Health
- ____ Dental care
- ____ Regular exercise
- ____ Breast / Testes self exam
- ____ Contraceptive counseling

Safety
- ____ Alcohol/Drugs/ smoking
- ____ STDs/AIDS
- ____ Gun safety

Psychosocial
- ____ Plans for future
- ____ Communication with parents

Assessment/Plan:

Screen: Dental referral _____
Cholesterol/Trig _____
if + family hx _____
CBC & UA _____
Vision _____
Audiometry _____
PPD _____

Provider _____

Camillus Health Concern, Inc.
Immunization Record

Last Name _____ First Name_____ Client #_____

Vaccine	Date given mm/dd/yy
DTP/DTaP[1]	
DTP/DTaP[2]	
DTP/DTaP[3]	
DTP/DTaP[4]	
DTP/DTaP[5]	
DTP/Hib [1]	
DTP/Hib [2]	
DTP/Hib [3]	
DTP/Hib [4]	
Td [1]	
Td [2]	
Td [3]	
OPV/IPV [1]	
OPV/IPV [2]	
OPV/IPV [3]	
OPV/IPV [4]	
Measles	
MMR 1	
MMR 2	
Hib 1	
Hib 2	
Hib 3	
Hib 4	
Hep B 1	
Hep B 2	
Hep B 3	
Varivax [1]	
Varivax [2]	
Td Booster	
Td Booster	

EXAM	DATE	RESULTS and COMMENTS
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
CXR		
Lead Level		
Sickle Cell Screen		

CAMILLUS HEALTH CONCERN, INC.
COMPREHENSIVE PEDIATRIC HISTORY

Last Name _____ First Name _____ Client # _____

Allergies: _____

1. Date	2. Name of Parent/Guardian	3. Care if Parent (s) Work/Away: Relative/Neighbor _____ Daycare _____ Hours/Day _____ Days/Week _____

4. Family History - Indicate relationship

Diabetes _____ Emotional illness _____ Birth defects _____
Lung disease/TB _____ Kidney/urinary disease _____ cancer _____
Mental retardation _____ Allergies/asthma _____ seizures _____
Heart disease/Stroke _____ Blood dyscrasias _____ hypertension _____
Substance abuse _____ other _____

5. Mother's Prenatal History

Conditions:
Hypertension _____ Rh _____ Alcohol amt. _____ OTC _____
Diabetes _____ X-ray _____ Tobacco amt. _____
S.T.D. (specify) _____ HbsAg _____ Prescription _____ Street drugs _____
Rubella _____ Other _____
Prenatal Care/Trimester begun: _____

6. Weeks gestation	Birth Weight	APGAR	Length	Head Circ.	Where delivered

7. Delivery History

SVD _____ Prolonged labor _____ Breech _____ PROM _____
Cesarean _____ Precipitous delivery _____ Forceps _____ Other _____

8. Neonatal Problems and Conditions

Deformities _____ Oxygen _____
Injuries _____ Irritability _____
Respiratory _____ Feeding _____
Cardiac _____ Incubator days _____
Jaundice _____ Tremors/seizure _____
Other (specify) _____

9. Infectious Disease/Date of Onset

Rubella _____ HIV _____
Measles _____ Hepatitis B _____
Pertussis _____ S.T.D. (specify) _____
Mumps _____
Chicken Pox _____ Other _____

10. Serious Illness, Accident, Hospitalization (s), Frequent Episodes of Minor Illness

Date: _____ Outcome: _____
Date: _____ Outcome: _____
Date: _____ Outcome: _____

_____
Signature/Title of Interviewer

CAMILLUS HEALTH CONCERN
DENTAL RECORD

DATE _____ NAME _____

ALERT

BIRTHDAY _____

CHC # _____ SEX _____

	YES	NO
1. ARE YOU UNDER THE CARE OF A PHYSICIAN? (ESTA USTED BAJO EL TRATAMIENTO DE ALGÚN MEDICO) REASON (RAZÓN): _____	☐	☐
2. ARE YOU TAKING ANY MEDICINE OR DRUGS? (ESTA TOMANDO ALGÚN MEDICAMENTO O DROGA) LIST (NÓMBRELOS): _____	☐	☐
3. HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? (HA ESTADO USTED HOSPITALIZADO EN LOS PASADOS 5 AÑOS) WHY? (POR QUE?): _____	☐	☐
4. ARE YOU ALLERGIC TO ANYTHING (DRUGS, FOODS)? (ES USTED ALÉRGICO A ALGO (MEDICINAS, COMIDAS) LIST (NÓMBRELOS): _____	☐	☐
5. HAVE YOU EVER HAVE ANY OF THE FOLLOWING? (HA TENIDO USTED ALGUNO DE LOS SIGUIENTES)		
HEART TROUBLE (PROBLEMAS DEL CORAZÓN) _____	☐	☐
RHEUMATIC FEVER (FIEBRE REUMÁTICA) _____	☐	☐
HIGH BLOOD PRESSURE (PRESIÓN ALTA O BAJA) _____	☐	☐
LIVER DECEASE (HEPATITIS) (PROBLEMA DEL HÍGADO) _____	☐	☐
EPILEPSY (SEIZURES) (EPILEPSIA) _____	☐	☐
CANCER _____	☐	☐
TUBERCULOSIS _____	☐	☐
ANEMIA _____	☐	☐
BLOOD DISEASE (PROBLEMAS DE SANGRE) _____	☐	☐
ASTHMA (ASMA) _____	☐	☐
A.I.D.S.-C.I.D.A. (S.I.D.A) _____	☐	☐
6. DO YOU SMOKE? PACKS PER DAY _____ (USTED FUMA? PAQUETES POR DÍA)	☐	☐
7. ARE YOU PREGNANT? _____ (ESTA USTED EMBARAZADA?)	☐	☐

8. IS THERE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE KNOW ABOUT, OR IS THERE ANY ACTIVITY YOUR DOCTOR SAYS YOU CAN NOT DO? (SI HAY ALGUNA ENFERMEDAD, CONDICIONA O PROBLEMA NO MENCIONADO ARRIBA QUE USTED PIENSE DEBAMOS SABER, O ALGUNA ACTIVIDAD QUE SU DOCTOR NO LE PERMITE HACER?) IF SO, EXPLAIN (SI ES ASÍ EXPLIQUE) _____

DENTAL HISTORY (HISTORIA DENTAL)

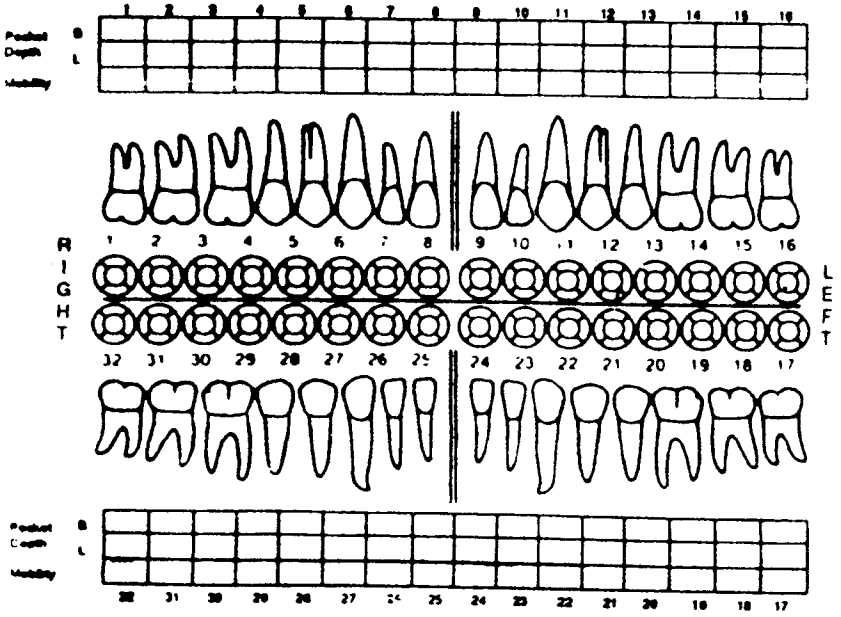
1. REASON FOR VISIT? (RAZÓN DE SU VISITA) _____
2. LAST DENTAL VISIT? (ULTIMA VISITA) _____ LAST COMPLETE EXAM (FECHA, EXAMEN COMPLETO) _____
3. DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR MOST DENTAL TREATMENT? YES _____ NO _____ (PREFIERE USTED ANESTESIA LOCAL (NOVOCAÍNA) PARA LA MAYORÍA DE SU TRATAMIENTO DENTAL)
4. HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____ (HA TENIDO USTED PREVIAMENTE ALGÚN PROBLEMA SERIO RELACIONADO CON EL TRATAMIENTO DENTAL)
5. DOES DENTAL TREATMENT MAKE YOU NERVOUS? NO____ SLIGHTLY____ MODERATELY____ EXTREMELY____ (EL TRATAMIENTO DENTAL LO PONE NERVIOSO?) (NO) (UN POCO) (BASTANTE) (EXTREMADAMENTE)
6. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUN DISEASE, PYORRHEA, TRENCH MOUTH) (HA SIDO TRATADO POR ENFERMEDAD PERIODONTAL (ENFERMEDAD DE ENCÍAS, PIORREA, GINGIVITIS ULCERATIVA) _____ IF YES WHEN (SI ES ASÍ CUANDO) _____

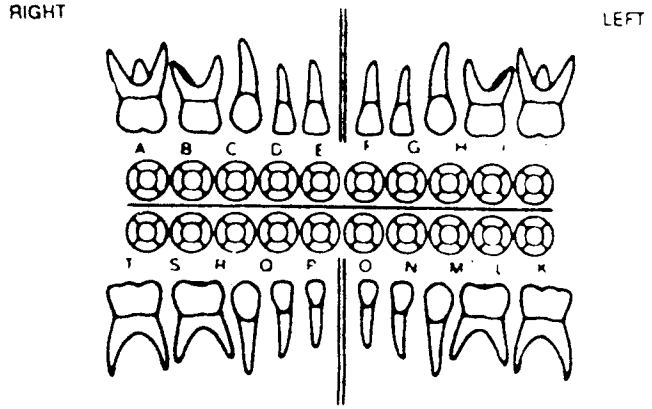
_____ Signature (Firma)

_____ Date (Fecha)

PLAN OF TREATMENT (PLAN DE TRATAMIENTO)

PROBLEMS (PROBLEMAS)	TREATMENT (TRATAMIENTO)	COST (COSTO)	FINAL TREATMENT (TRATAMIENTO FINALIZADO)





Date	Services Rendered

CAMILLUS HEALTH CONCERN INC.
Pediatric Progress Note / Episodic Visit

Date of Service	Date of Birth	Med Rec #	Age	Encounter Number

Last Name	First Name	Gender

Vital Signs: Ht _____ Wt _____ Temp _____ Bp _____

HR _____ RR _____ HC _____ Immunizations : Current _____ Defer _____

Allergies: Chief Complaint (walk ins only):_____ _____	***Medication List Update***

_____

PROVIDERS SIGNATURE

CAMILLUS HEALTH CONCERN INC.
Adult Progress Note / Episodic Visit

Date of Service	Date of Birth	Medical Record	Age	Encounter Number [redacted]

Last Name	First Name	Gender

Vital Signs: BP _____ HR _____ RR _____ WT _____ Temp _____

Allergies:

Living Situation:

F/U Appt _____ Walk In: Chief Complaint _____

_____

acco : never _____ yes _____: _____ ppd x _____; DC'd _____

Alcohol : no ___ significant past use ___ yes ____: amount _____

Drugs: never _____ significant past use _____ active use _____

IVDU ___ Nasal cocaine ___ crack cocaine ___ marij. ___ other____

Medication List - Update

_____
PROVIDERS SIGNATURE

Camillus Health Concern, Inc.

Chronic Problem List

Patient Name ____________________

CHC No. ____________

Date	Problem	Onset	Ongoing	Resolved	Related Studies / Comments	PAS

Camillus Health Concern, Inc.
Preventative Care Data Form

Name _____ DOB _____ SEX: M F CHC#: _____

_____ JMH#: _____

HIV TESTING:	DATE								
	Result (Pos./Neg.)								
	Location								
	Documentation (Y<N)								

RPR:	DATE								
	Result (titer, NR)								
	Treatment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
	Treatment Date Completed								

PPD:	DATE							
	Result (mm, NR)							
	Control POS,, NR)							

DIABETES FUNDOSCOPIC/ PODIATRY:	APPT DATE							FAMILY HISTORY
	Seen (Y, N)							
	Podiatry (DateSeen)							

WOMEN'S HEALTH:	CBE DATE						
	Mammogram Date						
	Pap Smear Date						

DIGITAL RECTAL EXAM:	DATE						
	Prostate (Neg. Abn.)						
	PSA						
	F.O.B. (Pos. / Neg.)						
	Sigmoid/ B. E. Date						

IMMUNIZATIONS	Influenza							
	Pneumococcal							
	Td							

Camillus Health Concern, Inc.
Diabetes Maintenance Form

Name: ______________________ **CHC #:** ______________________

Date	BG	HbA1C	BP	mAlb	sCR / CrCl	TC/HDL/LDL/TRIG	Foot(S.W.)	Fundoscopy Date
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
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Medication Changes:

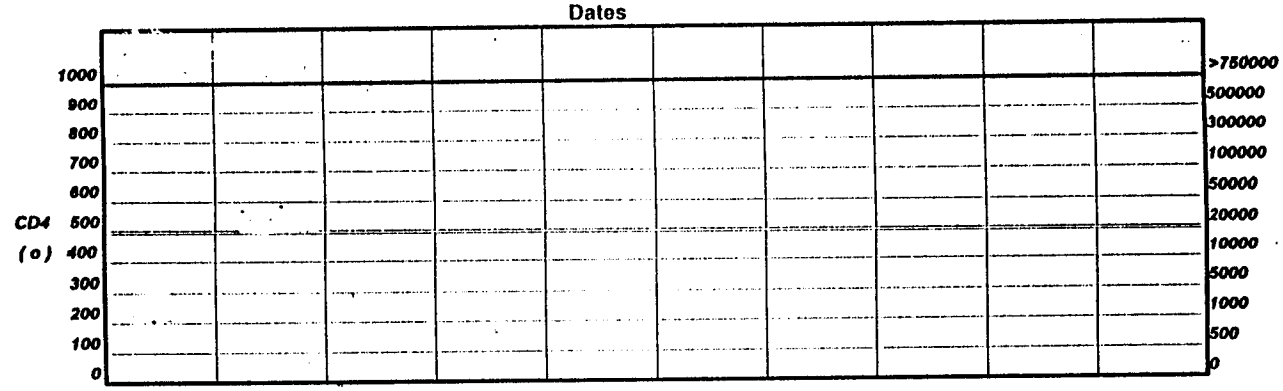
Camillus Health Concern, Inc

HIV Specific Flow Sheet

Patient Nam

CHC No.

Dates



	Date	Result		Date	Result	Date	Result	Date	Result	Date	Result	Date	Result
HBsAg			HIV serology										
HBsAb			RPR										
HCV Ab			Toxo IgG										
G6PD			PPD										
Pneumovax			Influenza										
Td			Recombivax										
CXR													
Pap Smear													
Pap Smear													

Date Sarted	Medication(s), Dosage, Dosing	Date Discontinued

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RESPONSIBILITIES

- **You have the responsibility to be considerate and courteous** to other clients and Camillus staff.

- **You have the responsibility and the right to participate in decisions** related to your care.

- **You are responsible to be open and honest with us** about instructions you receive concerning your health. Let us know immediately if you do not understand them, or if you feel you cannot follow them.

- **You are responsible to bring with you information about past illnesses,** hospitalizations, medications, and other matters related to your health and/or social history.

- **You are responsible to be on time for scheduled appointments,** or to contact us if you cannot make the appointment.

- **You are responsible to know and follow** the Camillus Code of Conduct (see posting in waiting room).

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RIGHTS

- **You have the right to receive the best care indicated for your problem** regardless of your gender, race, color, religion, national origin, age, economic status, disability, sexual orientation, or lifestyle.

- **You have the right to be treated respectfully by others** and to be addressed by your proper name without undue familiarity.

- **You have the right to confidentiality of all records and communications.** However, there are limitations to maintaining confidentiality; for example, under the law we are mandated to report the abuse of children, elderly, and disabled. If you have any questions, please ask us.

- **You have the right to review your medical record,** to request amendments, and to request copies of the your medical record.

- **You have the right to know all services available** at Camillus Health Concern, Inc. (CHC)

- **You have the right to know that when the clinic is closed** you can contact your health care provider by calling (305) 577-4840.

- **You have the right to know that all CHC health care providers** are licensed professionals and experienced in the provision of health care.

- **You have the right to seek and receive easily understood information necessary** for you to make informed decisions about your health, social, or psychological situation, including an explanation of all procedures and treatments, and including information about your health care plan, if applicable.

- **You have the right and responsibility to participate in decisions** related to your care.

- **You have the right to appropriate emergency services by** contacting 911, or going directly to the nearest emergency room, or, if necessary, by referral from a CHC health care provider.

- **You have the right to refuse care** by any health care provider and to request a different health care provider if one is available.

- **You have the right to refuse treatment to the extent** permitted by law and be informed of the consequences of that action.

- **You have the right to know when students** are to perform specific examinations or treatment that pertain to your care.

- **You have the right to refuse participation in any research** study or project.

GRIEVANCES

- If you feel you are not bring treated fairly or properly, you have the right to formally address your complaint or problem by filing a grievance; however, we encourage you to first speak with a supervisor so that the problem can be immediately resolved.
- We have a grievance process, which allows for you to discuss your concerns with Camillus Management.
- To register a grievance:
  You may request a grievance form at the Reception Desk.

  Or

  You may write a letter to:
  Director of Operations
  Camillus Health Concern, Inc.
  336 N.W. 5th Street
  Miami, FL 33128