Camillus Health Concern, Inc.
Financial Assessment/Sliding Fee Assignment

Date: _____ Medical Record #_____

Name:_____
Last Name First Name DOB

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

Family Size/Members (including yourself): _____

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4._____

Sliding Fee Assignment: ☐ A ☐ B ☐ C ☐ D

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: _____

Living Situation:
☐ Street ☐ Car ☐ Motel ☐ Shelter ☐ Doubled up ☐ Not homeless
☐ Transitional Housing ☐ Substance abuse/mental health tx center ☐ Apt/house<12 months

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.
Progress Note

Client Name: _____ Record# _____ Date: ___/___/___

Location: _____ ❑Client Seen ❑Family Seen ❑Seen in Group

Subjective: _____

Objective/Current Symptoms/Mental Status: _____

_____

_____

_____ Lab Data: _____

❑ Psychotherapy Provided/(Relevant Issues/Events): _____

_____

_____

_____

Technique(s) Utilized: _____ Response to Interventions: _____

Problems Status Refer to the Initial Treatment Plan

Status:	Met	New Goal	Improving	Worsening	No Change	Progress Towards Goal / Lack Thereof:
Problem #1						
Goal #1	❑	❑	❑	❑	❑	_____
Goal #2	❑	❑	❑	❑	❑	_____
Goal #3	❑	❑	❑	❑	❑	_____
Problem #2						
Goal #1	❑	❑	❑	❑	❑	_____
Goal #2	❑	❑	❑	❑	❑	_____
Goal #3	❑	❑	❑	❑	❑	_____

Assessment / Diagnosis: ❑ Major Depression ❑ Dysthymic D/O ❑ ADHD ❑ SCPT ❑ Schizoaffective D/O

❑ Panic Disorder ❑ Generalized Anxiety Disorder ❑ Post Traumatic Stress D/O ❑ Bipolar Disorder

❑ Other (Specify): _____

GAF (Global Assessment of Functioning: 0-100:_____

Plan: ❑ Medication Management ❑ Psychotherapy (Reason for Continued Treatment): _____

_____

CONTINUE	CHANGE	START	D/C	MEDICATION	DOSAGE	FREQUENCY	SIDE EFFECTS OR COMMENTS
❑	❑	❑	❑				
❑	❑	❑	❑				
❑	❑	❑	❑				
❑	❑	❑	❑				
❑	❑	❑	❑				
❑	❑	❑	❑				

❑Discussed Risks/Benefits of Medication with the Client

❑ Return to Office in: ❑ ____Weeks ❑ ____Months ❑ Communicate❑ with PSP

Time Spent: ❑ 15 ❑ 20-30 ❑ 45-50 ❑ 60 ❑ 80 ❑ Refer for: _____ ❑ D/C From Treatment

Signature: _____ Name _____ Credential/Title:_____

15 = 4 HP/3Dx	10 ros	2 in 9 PE
14 = 4HPI/3Dx	2-9 ros	12-17 PE
13 = 1-3 HPI	1 ros	6-11 PE
12 = 1-3 HPI	0 ros	1-5 PE

CAMILLUS HEALTH CONCERN INC.
Adult Progress Note / Episodic Visit

Date of Service	Date of Birth	Medical Record	Age	Encounter Number

Last Name	First Name	Gender

(Medication List - Update)

F/U appt_____ Walk In_____ Pain 1-10_____

PFH update _____ No Change to PV _____

PsoH update _____ No Change to PV _____

CC:

HPI:

ROS	N	P
Constit		
Skin		
Eyes		
ENT		
Resp		
Card		
Vascular		
GI		
GU		
GYN		
Endoc		
Musculskel		
Neuro		
Heme		
Lymph		

VS: BP_____ HR_____ RR_____ Wt_____ Tmp_____

Allergy:

A/P

Counseling	
Tob Cessation	
Weight Loss	
Exercise	
Diet Low Fat	
Diet Low Cal	
Diet Low Na -	
Diet Low Carb	
STD prevent	
GERD prec	
Subst Use	
Diabetes Ed	
NC w/Rx	
Rx SE	

PROVIDERS SIGNATURE

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.
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 _____ siezures _____
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
HEALTH MAINTENANCE ASSESSMENT - ADOLESCENT VISIT

Date:_____ Date of Birth:_____ Age:_____ Client Number_____

Last Name:_____ First Name:_____ Gender:_____

Medications:_____ Allergies:_____

Social Hx:_____

Immunizations: current ☐ defer ☐

Diet (24 hrs.)
_____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 activities_____
Drugs_____ Sexual activity_____
Menstrual Hx_____

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

Subjective:

Unclothed Physical Exam:

	Normal (■)	Abnormal (O)
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. Musculoskeltal:		
a. Extremities:		
b. Spine:		
15. Neurological:		

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:_____

8/96

Camillus Health Concern, Inc

Patient Name_____

HIV Specific Flow Sheet

CHC No. _____

Dates

CD4 (o)											Viral Load (X)
1000											>750000
900											500000
800											300000
700											100000
600											50000
500											20000
400											10000
300											5000
200											1000
100											500
0											0

	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