CARROLL COUNTY
GENERAL HEALTH DISTRICT
Healthy People — Safe Communities

# CONSENT FOR EXAMINATION, TREATMENT and PAYMENT

I request Carroll County Health Department to perform an examination and/or lab tests on me. I understand that all reasonable attempts will be made to contact me if any test result ordered by a Health Department physician is abnormal.

In consideration of the above-mentioned services rendered to me by the Carroll County Health Department, I hereby release and forever discharge the Carroll County Health Department and its Trustees, Board Officers, Employees, Clinic Physician and Nursing Staff from all claims, damages, actions and causes of action arising out of any injury or damages resulting from said service or any effect thereof presently known or unknown now and forever in the future.

Every client shall receive equal consideration and not be excluded from participation in or be denied the benefits of or otherwise be subjected to discrimination on the grounds of race, sex, national, origin, color or handicap.

I agree to accept responsibility for any additional and/or follow-up care that may not be available from the Carroll County Health Department. I give my permission to the employees of the Carroll County Health Department and others authorized by them to use information contained in my medical record for statistical purposes, and as required by law, with the understanding that confidentiality will be maintained. Client confidentiality will be upheld without notification to the parent or legal guardian as applicable. We cannot give out any information about you to anyone without your consent. ***EXCEPTION: If you report any physical abuse, sexual abuse, or report feeling suicidal or homicidal, by law, we must find someone to help you.***

The goal of the Carroll County Health Department is to promote the health and well being of all that receive our services. There is no residency requirement to participate in the Carroll County Health Department Reproductive Health Clinic.

Fees for all services are expected on the date of service. For those who may have difficulty paying upon request may set up a payment plan with the billing office, this must be set up prior to the appointment and a payment must be made at the time of service. We accept Medicaid, Private insurance, cash or check and credit card (Fee of 3% or $2.00 whichever is greater) for payment.

**My signature verifies that all information provided to the Carroll County Health Department is truthful and accurate to the best of my knowledge. My signature is also agreement to provide payment of all charges at the time of service.**

Parent or Client Signature_____ Date of Service_____

Client Name_____ SSN_____ Date of Birth_____

**If you have the following insurances Aultcare, Cigna, Medical Mutual, Anthem BC/BS, Tricare, Aetna, Ohio Health Choice, Summa, Priority Health, United Health Care, Health America, Health Smart, Multiplan, Pai, The Health Plan of the Upper Ohio Valley Please fill out the following information so we can bill your insurance correctly and efficiently**.

| |
|---|
| **Name of Person who carries the Insurance if Different then client:** |
| **Relation to Client:** |
| **Date of Birth of Insurance Carrier:** |
| **Social Security Number of Insurance Carrier:** |

**Office Use Only**
Witness Signature _____ Date of Service _____
Revised 8/15/2018 Initial 9/19/2016

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# Reproductive Health Plan

Name: _____ Date of Birth: _____ Date: _____

What is your weekly Income: _____ How many people live in your home? _____
Are you a student? □ Yes □ No How many children are living with you currently? _____

What is the highest grade you have completed? _____

How do you plan to pay today? □ Medicaid □ Private Insurance □ Self Pay □ No Pay

Donation for services today? □ Yes □ No

When you first started having sec what did you use for birth control?
□None □ Condoms □ Depo □ Oral Birth Control □ IUD □ Other: _____

What form of birth control do you plan to use after your visit today?
□None □ Condoms □ Depo □ Oral Birth Control □ IUD □ Other: _____

How often do you condoms? □ Not Applicable □ Always □ Never □ Sometimes

Do you want to become pregnant within the next year? □ Yes □ No

Do you want to have children one day? □ Yes □ No

*If yes:*

At what age you would like to have children? _____
How many children would you like? _____
How far apart would you like your children to be? _____

*If no:*

What will you do if you do become pregnant? _____

If you are currently pregnant:

Did you intend to become pregnant? □ Yes □ No
Were you using a form of contraception? □ Yes □ No
If Yes, □ Condoms □ Depo □ Oral Birth Control □ IUD

I currently have children □ Yes □ No How many children? _____ How many pregnancies have you had?_____

## Almost Done! Turn Page Over!

## Personal Habits

If you are a current smoker are you thinking about quitting? ☐ Yes ☐ No If yes, How soon would you like to quit?
Would you like services for quitting? ☐ Yes ☐ No _____
Are you having sex with more than one partner/person? ☐ Yes ☐ No
Do you sometimes go on unhealthy diets or overeat? ☐ Yes ☐ No
Do you use street drugs or prescription drugs for fun? ☐ Yes ☐ No

## Emotional Health

When you feel sad do you bounce back quickly or feel sad for 2 weeks or more? ☐ Yes ☐ No
How often do you feel nervous, anxious, or worried? _____
How do you calm yourself down if you are angry? _____
Is there anyone in your life who physically hurts you? ☐ Yes ☐ No
Is there anyone in your life who often says hurtful or mean things? ☐ Yes ☐ No

## Important Vaccinations
## Check all vaccinations you have received:

☐ Tetanus/Tdap
☐ Hepatitis
☐ Hepatitis B
☐ Gardasil (HPV)
☐ Varicella (chicken pox)
☐ Measles, Mumps, Rubella
☐ Inactivated Polio Virus
☐ Pertussis (whooping cough)

## Family History
### Check all of those which have happened in your immediate family:

☐ A baby born too soon or weighing less than 5 ½ pounds
☐ High blood pressure in pregnancy
☐ Diabetes in pregnancy
☐ Two or more miscarriages
☐ Stillborn baby
☐ Baby with a heart defect
☐ Stroke
☐ Asthma
☐ Heart of Lung Disease
☐ Other: _____

## Personal Goals:

I will take a daily multivitamin or prenatal vitamin with folic acid. ☐

I will start exercising or exercise more often. ☐

I will **quit** smoking or **smoke less**. ☐

I will **increase** or **always** use condoms when having sex. ☐

I will **quit** or **decrease** the amount of alcohol or drugs I use. ☐

I will **increase**, **maintain** or **reduce** my weight. ☐

I will not get pregnant until I am ready by not having sex or by always using birth control. ☐

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# Health History

**Name:**_____ **Date of Birth:** _____ **Age:** _____

**Are you Allergic to any medication/Herbs/Vitamins?** _____

**Are you Allergic to anything else:** _____

**Recent Changes in Family Medical History:** _____

**Have you in the past 12 months been: Hospitalized ☐ Yes ☐ No Surgery ☐ Yes ☐ No Major Illness ☐ Yes ☐ No**

**Current Birth Control Method: ☐ None ☐ Depo ☐ Nexplanon ☐ Oral Birth Control ☐ IUD Problems: ☐ Yes ☐ No**

**Do you desire a Different Method: ☐ Yes ☐ No When was the 1st day of your last period?** _____

**How many Sexual Partners in past 12 months?** _____

**How long have you been with your current partner?** _____

**Do you have any new problems or questions for us?** _____

**Do you currently smoke? ☐ Yes ☐ No How much do you smoke daily?** _____

**Do you drink alcohol? ☐ Yes ☐ No How many drinks do you have a day?** _____ **How often?** _____

**Do you use street drugs? ☐ Yes ☐ No What type?** _____ **How often?** _____

**Do you use prescription drugs/over the counter drugs to get high? ☐ Yes ☐ No How often?** _____

**Would you like any of the Following services while you are here today?**

☐ STD Testing
☐ HIV Testing
☐ Hepatitis C
☐ HPV – Gardasil Vaccine
☐ Flu Shot

## Almost Done! Turn Over the page!

# Are you currently experiencing any of these symptoms?

# Check All symptoms that apply to you:

**GENERAL**
- ☐ Chills
- ☐ Fever
- ☐ Sweats
- ☐ Dizziness/Fainting
- ☐ Headaches
- ☐ Change in sleep pattern
- ☐ Numbness/Pain
- ☐ Skin (rash/bruise/sores/mole change)
- ☐ Other

**GASTROINTESTINAL**
- ☐ Poor appetite
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Indigestion
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Stomach Pain

**CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Varicose veins
- ☐ Shortness of breath

**GENITO-URINARY**
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of bladder control

**Eyes, Ears, Nose and Throat**
- ☐ Sinus problems
- ☐ Persistent cough
- ☐ Difficulty swallowing
- ☐ Nosebleeds
- ☐ Hoarseness

**Reproductive**
- ☐ Breast Lump
- ☐ Irregular bleeding
- ☐ Nipple discharge
- ☐ Vaginal discharge

Are you in a relationship (partner/family member/other) in which you have been physically hurt or threatened? ☐ Yes ☐ No
Explain _____

Do you ever feel afraid or threatened by your partner/family member/other? ☐ Yes ☐ No
Do you feelings of:

- ☐ Depressed Mood
- ☐ Lack of energy
- ☐ Feeling of guilt/worthlessness
- ☐ Trouble Sleeping
- ☐ Sleeping to Much
- ☐ Thoughts of Suicide

Have you ever been pressured or forced to have sex? ☐ Yes ☐ No

Have you ever had sex to get money or drugs? ☐ Yes ☐ No

Are you aware that the safest type of sex is no sex? ☐ Yes ☐ No

Is your family aware that you are a client at our clinic? ☐ Yes ☐ No

Is there anything else you would like us to know? _____