



1095 N. 1st Avenue, Stayton, OR 97383

503-767-3226

503-769-2175 (after hours)

Thank you for choosing Canyon Family Health for your primary care!

We are happy to help you meet your health care goals.

There are a few things we would like you to know about the clinic:

- Clinic hours are Monday—Thursday from 7 AM – 4:30 PM and Friday from 7 AM – 12 PM.
- After hours triaging is shared with Santiam Hospital. If you have an urgent after-hours medical concern, please call (503)769-2175 and a medical provider will be paged to assist you. Do not leave a voicemail at the clinic or send a private email to Maria for urgent needs. Please note, on-call providers will not be able to prescribe medication refills.
- All true emergencies should be transported via ambulance (911) to the nearest hospital. Contact the paging service after-hours for any other urgent concerns rather than having an expensive and unnecessary emergency room visit.
- We reserve time daily for acute visits such as coughs and sports injuries. Our staff is skilled at assessing the need to use these appointments. Please call us first before seeking the emergency room or urgent care.
- The patient portal is a GREAT way to communicate with us. You can register at <https://19037.portal.athenahealth.com/> or speak with staff about this feature. While we can normally respond on the same day, please allow up to 48 business hours for a response. If it is more urgent, please call the clinic directly. All non-emergent medical triage calls will be returned within 48-business hours.
- The patient portal is also a great way to view your medical history. You can log-on and download any part of your medical record to share with other providers or keep for your own records.
- Refill requests should be made seven days prior to needing the medication so we can guarantee it is completed on time.

- It has become necessary to implement a “no-show” policy. No-show means that the patient either did not cancel the appointment at least two hours before the scheduled time or that the patient was over 10 minutes late to an appointment without calling ahead. Three no-show appointments will result in being dismissed from the clinic. Appointments will be rescheduled or canceled if the patient arrives over 10 minutes late and considered a “no-show”.
- We are currently not providing opioid medication for chronic conditions. If you need chronic opioid medications, we will refer you to pain management to have these prescriptions filled.
- To provide patients and families an opportunity to express concerns about their care, we ask that these are expressed to Maria Fife, FNP. Our goal is to provide high-quality, compassionate care. Often, problems are a result of misunderstanding that can be addressed with good communication. It is never our intent to upset our patients and we will work very hard to make sure you receive the care you need.
- At your first visit, please remember:
 - Arrive 20 minutes early
 - Bring a completed new patient packet
 - Bring a form of photo ID and your insurance card
 - Bring a copy of your medical records, if available

We value our patient’s time and try our best to respect appointment times. If the paperwork is not completed before your visit or you do not arrive on time, we might need to reschedule your visit.

We look forward to working with you!

Sincerely,

Maria, Crystal and Hope



Health Questionnaire

All questions in this document are strictly confidential and will become part of your medical record.

Name (Last, First, MI):	
Date of Birth:	
Assigned Sex at Birth:	Gender Identity
Previous Primary Care Provider:	
How did you hear about us?	
Preferred Pharmacy:	
Preferred Lab:	Santiam Hospital or other: _____
Preferred Imaging Facility:	Santiam Hospital or other: _____
Names/types of any specialists followed:	

Emergency Contact Name	Relationship	Phone Number

Health Insurance Carrier	Policy Number	Group Number
Primary		
Secondary		

Allergies	Reaction You Had



List any health problems you have now or had in the past

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List your prescribed medications and any over-the-counter (OTC) medications or supplements

Medication or Supplement	Dose	Frequency Taken

Surgical and Hospitalization History

Year (best estimate)	Reason	Location



List any significant health problems and ages (or age of death) of your family members
Father:
Mother:
Siblings:
Children:
Paternal Grandfather:
Paternal Grandmother:
Maternal Grandfather:
Maternal Grandmother:

Social History (circle best responses or write response)					
What type of diet are you following?	REGULAR	VEGETARIAN	VEGAN	DIABETIC	
	GLUTEN FREE	CARBOHYDRATE	CARDIAC	KIDNEY	
What is your exercise level?	NONE	OCCASIONAL	MODERATE	HEAVY	
What is the high grade level or degree completed?					
Are you currently employed?	YES	NO			
Are you able to care for yourself?	YES	NO			
What is your dominant hand?	LEFT	RIGHT	AMBIDEXTROUS		
Do you have smoke and carbon monoxide detectors in your home?			YES	NO	
Do you have an advanced directive?	YES	NO			
Is a blood transfusion acceptable in an emergency?			YES	NO	
What is your relationship status?	MARRIED	SINGLE	DIVORCED	WIDOWED	DOMESTIC PARTNER
Are you sexually active?	YES	NO			
How many children do you have?					
Do you participate in social media?	YES	NO			
What is your level of alcohol consumption?	NONE	OCCASIONAL	MODERATE	HEAVY	
Do you use any recreational or illicit drugs?			YES	NO	
What is your level of caffeine consumption?	NONE	OCCASIONAL	MODERATE	HEAVY	



Smoking History			
Are you exposed to passive smoking (does someone smoke around you)?	YES	NO	
Are there any smokers in your home?	YES	NO	
Do you smoke or have you ever smoked tobacco?	NEVER	FORMER (how long ago? _____)	
	CURRENT EVERYDAY SMOKER	CURRENT SOME DAYS SMOKER	
Do you or have you ever used any other forms of tobacco or nicotine?	YES	NO	
Do you or have you ever used e-cigarettes or vape?	NEVER	FORMER	CURRENT
Do you or have you ever used smokeless tobacco?	NEVER	FORMER	CURRENT TOBACCO CHEWER
	CURRENT SNUFF USER	CURRENT MOIST POWDER TOBACCO	

Gynecological History (Females only)					
Age of first menstrual cycle:					
Date of last menstrual cycle:	DEFINITE		APPROXIMATE		
Menses monthly?	YES	NO			
Date of last Pap smear?					
History of abnormal Pap smear?	YES	NO			
Current contraceptive method:	PILL	PATCH	RING	HORMONAL IUD	COPPER IUD
	ARM IMPLANT	PARTNER VASECTOMY		DEPO-PROVERA	HYSTERECTOMY
	TUBAL LIGATION	CONDOMS	ABSTINENCE	OTHER _____	
History of Sexually Transmitted Infections?					
Age of first pregnancy/child:					
If post-menopausal, age of menopause:					
Obstetric History:					
Total Pregnancies	Total Full Term Births		Total Premature Births		
Total Abortions Induced	Total Abortions Spontaneous		Ectopic Pregnancies		
Multiple Births	Number of Children Still Living				

Are you here seeking buprenorphine treatment (MAT) for opioid use disorder?	YES	NO
Is the opioid used heroin (smoke or injection)?	YES	NO
We are unable to initiate treatment for those currently using heroin.		



Circle if you have, or have had, any of the following medical issues				
ADD/ADHD	AIDS/HIV	ABUSE/DOMESTIC VIOLENCE	ALLERGIES/HAYFEVER	ANEMIA
ANESTHESIA COMPLICATIONS	ANXIETY DISORDER	ARTHRITIS	ASTHMA	AUTISM SPECTRUM DISORDER
BEDWETTING	BIRTH DEFECTS	INHERITED DISEASE	BLADDER OR KIDNEY PROBLEMS	BLOOD TRANSFUSION
BREAST CANCER	BREAST PROBLEMS	COPD	CANCER	CHICKEN POX
CHRONIC EAR INFECTIONS	CONGESTIVE HEART FAILURE	CONSTIPATION	CORONARY ARTERY DISEASE	DEPRESSION
DEVELOPMENTAL OR BEHAVIOR DISORDERS	DIABETES	DIFFICULTY SWALLOWING	DIVERTICULITIS	EATING DISORDER
ECZEMA	ENDOMETRIOSIS	FIBROMYALGIA	GASTROINTESTINAL PROBLEMS	GOUT
HEADACHES	HEART DISEASE	HEART PROBLEMS	HEPATITIS	HIGH CHOLESTEROL
HOSPITALIZATIONS	HYPERTENSION	HYPERTHYROIDISM	HYPOTHYROIDISM	INFERTILITY
KIDNEY DISEASE	KIDNEY STONES	LIVER DISEASE	LUNG DISEASE	MRSA
MENIERE'S DISEASE	MENTAL HEALTH DISORDER	MUSCLE, JOINT OR BONE PROBLEMS	OBESITY	OSTEOPOROSIS
OVARIAN CANCER	POLYPS	PREECLAMPSIA	PULMONARY EMBOLISM	REFLUX/GERD
SEIZURE/ EPILEPSY	SKIN PROBLEMS	STROKE	THROMBOPHILIAS	THYROID PROBLEMS
TUBERCULOSIS	VARICOSE VEINS	VISION OR EYE PROBLEMS	OTHER:	

Please read the following statement:

I understand that Canyon Family Health will not prescribe chronic opioid medication for management of chronic pain. If I need these services, I will be referred to pain management. Members of Canyon Family Health will collaborate with the pain management specialists to optimize my treatment outcomes.

Please write yes and initial if you agree: _____

Thank you for taking your time to complete this packet before your first visit.
 When you are done, you can drop it off, fax it to (503)767-3227
 or email it to mariafife@canyonfamilyhealth.com.
 Once we receive your completed questionnaire, we will call to schedule an appointment.

Authorization to Discuss Medical Information

Patient Name: _____

Date of Birth: _____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

appointment dates/times diagnosis X-ray results medications

lab tests/results summary of medical record care plan

Indicate Confidential Information (initial):

mental health HIV Information alcohol/drug information

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please select one):

Date: _____

No expiration date

I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office, attention administrator

This authorization is giving Canyon Family Health the right to discuss my medication information with the one or more people listed above.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Signature: _____ Today's Date _____

Request for Records
(Please do not send records by CD)

Patient's Name: _____

Date of Birth: _____

I authorize the release of my medical records from:

Previous clinic/Provider

name: _____

Address: _____

____ Phone: _____ Fax: _____

**Please forward to CANYON FAMILY HEALTH 1095 N 1ST ST STAYTON,
OR 97383-1203 Phone: (503) 767-3226 Fax: 503-767-3227**

Information to be included

****Please initial the following:**

___ Chart notes and Medication List

___ Mental Health diagnosis and assessment (no chart notes)

___ Drug/Alcohol Treatment

___ Other (Please Specify) _____

Patient Signature: _____

Date: _____

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol:

One drink =



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	<input type="radio"/>	<input type="radio"/>

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>