1095 N. 1st Avenue, Stayton, OR 97383

503-767-3226

Thank you for choosing Canyon Family Health for your primary care! 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 the clinic to be transferred to a triage nurse. 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.

➢ 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 continue to receive refills, office visits need to be completed at least annually. If you do not have any new concerns, the annual preventive/wellness exam is a great way to touch base and ensure your health is in order. If we have not seen you in at least 2 years, we will consider you to be inactive and you will need to reestablish care.

➢We have 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. Two no-show appointments will result in being dismissed as a patient from the clinic. Appointments will be rescheduled or canceled if the patient arrives over 10 minutes late and will be considered a “no-show”.

➢ To provide patients and families an opportunity to express concerns about their care, we ask that these are expressed to Maria Fife, FNP either verbally or written. Our goal is to provide high-quality, compassionate care. Often, problems are a result of a misunderstanding that can be addressed with good communication. It is never our intent to upset our patients and we will work hard to make sure you receive the care you need.

➢To register as a new patient, please complete and return our New Patient Packet found on our website or call to request a packet to be mailed. We cannot schedule the first appointment without having this paperwork first.

➢ At your first visit, please remember:

- o Arrive 15 minutes early
- o Bring a form of photo ID and your insurance card
- o Bring a copy of your medical records, if available (we can request them if needed)

We look forward to working with you!

Sincerely,

Your Friends at Canyon Family Health

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:		
Address:		
Phone:		
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

List your prescribed medications and any over-the-counter (OTC) medications or supplements taken.		
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: ________________________________

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?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

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?	○	○

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

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:_____________________