OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

PATIENT INFORMATION

DATE: _____

_____ ____/____/____ M_| F_ _____-_____-_____
FIRST NAME MIDDLE INITIAL LAST NAME DATE OF BIRTH SEX SOCIAL SECURITY #

___(_____)_____ ___(_____)_____ ___(_____)_____
CELL NUMBER HOME NUMBER WORK NUMBER

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

_____ _____ _____
EMAIL ADDRESS PREFERRED NAME (If different from above) TYPE (birth, maiden, alias, preferred)

PROVIDER SEEN MOST OFTEN: _____

PREFERRED APPOINTMENT REMINDER METHOD: (circle one) NO REMINDER PHONE CALL TEXT MESSAGE

EMPLOYER:

_____ (_____)_____ _____
EMPLOYER PHONE NUMBER OCCUPATION

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

I ALLOW THE FOLLOWING DISCLOSURE OF HEALTHCARE INFORMATION TO THE FOLLOWING CONTACTS. THIS AUTHORIZES STAFF TO SPEAK TO THE LISTED CONTACTS FOR ALL APPOINTMENTS, CLINICAL INFORMATION AND FINANCIAL INFORMATION.

CONTACTS:

PRIMARY CONTACT RELATIONSHIP: _____ (_____)_____ (_____)_____
PHONE NUMBER TYPE (CELL / HOME)

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SECONDARY CONTACT RELATIONSHIP: _____ (_____)_____ (_____)_____
PHONE NUMBER TYPE (CELL / HOME)

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

GUARANTOR (Responsible party for payment). Complete only if the responsible party is NOT the patient. ___/___/___ _____-_____-_____
DATE OF BIRTH SOCIAL SECURITY #

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SIGNATURE _____ _____ _____
PATIENT'S SIGNATURE / LEGAL GUARDIAN DATE TIME

_____ _____ _____
WITNESS DATE TIME

OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

HOUSEHOLD INCOME SURVEY - MONTHLY

2025

Date: _____ **Name:** _____ **DOB:**_____

THIS IS ONLY A SURVEY. This information is only used to gain insight into the needs of our patients. Please circle the family size and monthly income that best represents your household.

Family Size	Level 1	Level 2	Level 3	Level 4
1	0	1,305	1,957	Over
	1,304	1,956	2,608	2,608
2	0	1,764	2,645	Over
	1,763	2,644	3,525	3,525
3	0	2,222	3,332	Over
	2,221	3,331	4,442	4,442
4	0	2,680	4,020	Over
	2,679	4,019	5,358	5,358
5	0	3,139	4,707	Over
	3,138	4,706	6,275	6,275
6	0	3,597	5,395	Over
	3,596	5,394	7,192	7,192
7	0	4,055	6,082	Over
	4,054	6,081	8,108	8,108
8	0	4,514	6,770	Over
	4,513	6,769	9,025	9,025
9	0	4,972	7,457	Over
	4,971	7,456	9,942	9,942
10	0	5,430	8,145	Over
	5,429	8,144	10,858	10,858
11	0	5,889	8,832	Over
	5,888	8,831	11,775	11,775
12	0	6,347	9,520	Over
	6,346	9,519	12,692	12,692
13	0	6,805	10,207	Over
	6,804	10,206	13,608	13,608
14	0	7,264	10,895	Over
	7,263	10,894	14,525	14,525
15	0	7,722	11,582	Over
	7,721	11,581	15,442	15,442

OZARKS COMMUNITY HEALTH CENTER
MEDICAL · DENTAL · BEHAVIORAL HEALTH

ADULT HEALTH HISTORY

ADULT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of birth: _____

Have you personally ever had any of the following conditions:

____ Blood Transfusions
____ Transfusion Reaction
____ Blood Disorders
____ Anemia
____ MRSA
____ VRE
____ Cancer
____ Chemotherapy
____ HIV
____ Genetic Disorder
____ Birth Defect
____ CVA
____ Seizures
____ Headaches
____ Neurological Disorders
____ Heart Attack
____ Heart Murmur
____ Congestive Heart Failure
____ Deep Vein Thrombosis
____ Hypertension (High BP)
____ Cardiac Disorders
____ COPD

____ Asthma
____ Pneumonia
____ Pulmonary Embolism
____ Respiratory Disorders
____ Hepatitis
____ GERD
____ Ulcer
____ Other GI Disorders
____ Renal Disease
____ Kidney Stones
____ Urinary Tract Infection
____ Prostate Problems
____ Genitourinary Disorder
____ Menstrual Problems
____ STDs
____ Pelvic Inflammatory Dx
____ Endometriosis
____ Fibroids
____ Pregnancy Complication
____ Preterm
____ Reproductive Disorders
____ Arthritis

____ Degenerative Disk Dx
____ Back Pain
____ Fractures
____ Musculoskeletal Disorder
____ Diabetes
____ Diabetic Ketoacidosis
____ Thyroid Disease
____ Liver Disease
____ Endocrine Disorders
____ Anxiety
____ Depression
____ Schizophrenia
____ Bipolar Disorder
____ Suicide Attempt
____ Mental Health Problems
____ Psychiatric Treatment
____ Behavior Problems
____ Glaucoma
____ Eye Injury
____ Ear Infection
____ Sinus Problems
____ Throat Problems
____ IV or Oral Bisphosphonates

Other: _____

____ Past Smoker
____ Current Smoker

____ Alcohol Use
____ Substance Abuse

____ Do you want help to quit?
____ Wear Contacts/Glasses

Family History		Relation	Description
Cancer	☐ Yes ☐ No		
Neurological Problems	☐ Yes ☐ No		
Cardiac Disorders	☐ Yes ☐ No		
GI Disorders	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Respiratory Disease	☐ Yes ☐ No		
Renal Disease	☐ Yes ☐ No		
Blood Disorders	☐ Yes ☐ No		
MS Disorders	☐ Yes ☐ No		
Mental Health Disorders	☐ Yes ☐ No		
Alcohol/Substance Use Disorders	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Other doctors I see: _____

Home Medical Supply: _____ Physical Therapy: _____

ADULT PATIENT HISTORY QUESTIONNAIRE -CONTINUED-

Pharmacy of Choice: _____ City: _____

Allergies: _____

Medications	Strength	How often taken
(example) Lanoxin	.0125 mg	Once a day in the evening

Surgeries	Date

Preventive Information

Test	Date	Location	Test	Date	Location
Mammogram			Fasting glucose		
Pap Smear			Abdominal Aneurysm Screening		
Colonoscopy			Pneumonia Shot		
Stool Cards			Shingles Vaccine		
Bone Density			TDAP/Tetanus Vaccine		
Cholesterol			Flu Vaccine		

I, the undersigned, do acknowledge I have completed this form honestly and to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

OZARKS COMMUNITY HEALTH CENTER
MEDICAL · DENTAL · BEHAVIORAL HEALTH

PRAPARE SURVEY

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Please complete this assessment specific to the patient.

Patient Name: _____ Date of birth: _____Date: _____

Address: _____

Housing & Income

1. What is your housing situation today?
   - ❑ I have housing
   - ❑ I do not have housing (staying with others, in a hotel, shelter, street, car, park, etc)
   - ❑ I choose not to answer

2. Are you worried about losing your housing?
   - ❑ Yes ❑ No
   - ❑ I choose not to answer

3. Household Size:
   - _____ Total Number of family members
   - ❑ I choose not to answer

4. Estimated annual household income
   - Income: $_____

Material Security

5. In the past year, have you or any family members you live with been **unable** to get any of the following when it was really needed?
   - Unable to get food
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
   - Unable to get clothing
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
   - Unable to get utilities
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
6. Unable to get child care
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
7. Unable to get medicine or any health care (medical, dental, mental health, vision)
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
8. Unable to get phone service
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
9. Unable to get housing or housing repair
   - ❑ Yes ❑ No
   - ❑ I choose not to answer

Insurance

10. What is your main insurance?
    - ❑ None/Uninsured ❑ Private insurance
    - ❑ CHIP Medicaid ❑ Medicaid
    - ❑ Other public insurance (CHIP) ❑ Medicare
    - ❑ Other public insurance (not CHIP)

Transportation/Isolation

11. Has lack of transportation kept you from appointments, meetings, work, or from daily living needs?
    - ❑ Yes, it has kept me from appointments/medications
    - ❑ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
    - ❑ No lack of transportation
    - ❑ I choose not to answer

12. How often do you see or talk to people that you care about and feel close to?
    - ❑ Less than once a week
    - ❑ 1-2 times a week
    - ❑ 3-5 times a week
    - ❑ 5 or more times a week
    - ❑ I choose not to answer

Violence/Stress

13. Do you feel physically and emotionally safe where you currently live?
    - ❑ Yes ❑ No
    - ❑ I choose not to answer
14. In the past year, have you been afraid of your partner or ex-partner?
    - ❑ Yes ❑ No ❑ Unsure
    - ❑ I have not had a partner in the past year
    - ❑ I choose not to answer
15. How stressed are you?
    - ❑ Not at all ❑ Quite a bit
    - ❑ A little bit ❑ Very much
    - ❑ Somewhat ❑ I choose not to answer

Employment/Education

16. What is your current work situation?
    - ❑ Unemployed
    - ❑ Part-time or temporary work
    - ❑ Full-time work
    - ❑ Otherwise unemployed, but not seeking work (student, retired, disabled, unpaid primary care giver)
    - ❑ I choose not to answer

17. What is the highest level of school that you have finished?
    - ❑ Less than high school
    - ❑ More than high school
    - ❑ High school diploma/GED
    - ❑ I choose not to answer

Personal Characteristics

18. Which race(s) are you? Check all that apply.
    - ❑ Asian Indian
    - ❑ Native Hawaiian
    - ❑ Pacific Islander
    - ❑ Black/African American
    - ❑ White
    - ❑ American Indian/Alaskan Native
    - ❑ Chinese
    - ❑ Japanese
    - ❑ Korean
    - ❑ Vietnamese
    - ❑ Other Asian
    - ❑ Samoan
    - ❑ Other Pacific Islander
    - ❑ Guamanian or Chamorro
    - ❑ Filipino
    - ❑ More than one race
    - ❑ I choose not to answer
    - ❑ Other

    If other, (please write):_____

19. What Ethnicity are you?
    - ❑ Mexican, Mexican American or Chicano/a
    - ❑ Cuban
    - ❑ Puerto Rican
    - ❑ NOT Hispanic, Latino/a or Spanish Origin
    - ❑ Hispanic, Latino/a or Spanish Origin
    - ❑ I choose not to answer

20. What language are you most comfortable speaking?
    - ❑ English
    - ❑ Other (please write):_____
    - ❑ Requires an Interpreter:_____
    - ❑ I choose not to answer

Situational Characteristics

21. Have you served in the United States military, armed forces or uniformed services?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

22. In the past year, have you spent more than 2 nights in a row in a jail, prison, or juvenile correction facility?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

23. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

24. Are you a refugee?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

Community Services

25. Do you need assistance with any of the following?

Renewal maintenance of MO Healthnet coverage/food stamps
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Application assistance
(social service organizations, Medicaid, etc)
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Budgeting/financial literacy
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Health/disease education
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

26. Are you currently a foster, kinship, or adoptive parent or child?
    - ❑ Parent
    - ❑ Child
    - ❑ No

27. If yes, do you need any of the following?

Foster child care/Respite care
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Foster transition assistance/planning (change in placement, transitioning out of care, youth services and/or juvenile justice)
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

28. Communication Issues?
    - ❑ Hard of Hearing
    - ❑ Legally Blind
    - ❑ Mute
    - ❑ Registered Service Animal
    - ❑ Uses TTD Phone
    - ❑ Prefers Forms/Read aloud
    - ❑ Difficulty Reading
    - ❑ None of the above
    - ❑ I choose not to answer

29. Our health center offers a Sliding Fee Discount Program to help reduce the cost of care based on household income and size. Would you like to apply for this program today?
    - ❑ Yes, I would like to apply
    - ❑ No, I decline at this time
    - ❑ Already Enrolled

30. Would you like an OCHC Community Health Worker (CHW) to help you with anything on this form?
    - ❑ Yes
    - ❑ No