



OB PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
 DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE: HOME _____ CELL _____ WORK _____
 EMAIL ADDRESS (for patient portal access): _____
 EMPLOYER _____ OCCUPATION _____

RACE:

<input type="radio"/> White	<input type="radio"/> Asian	<input type="radio"/> Other
<input type="radio"/> Black/African American	<input type="radio"/> Hispanic or Latino (no race info available)	<input type="radio"/> Decline to Report
<input type="radio"/> American Indian or Alaskan Native	<input type="radio"/> Native Hawaiian or Pacific Islander	

ETHNICITY:

<input type="radio"/> No, not Spanish/Hispanic/Latino	<input type="radio"/> Decline to Answer	<input type="radio"/> Unknown
<input type="radio"/> Yes/Cuban <input type="radio"/> Yes/Puerto Rican	<input type="radio"/> Yes, Mexican, American, Chicano	<input type="radio"/> Yes, Other Hispanic <input type="radio"/> (Specify) _____

PREFERRED LANGUAGE:

<input type="radio"/> English	<input type="radio"/> Spanish	<input type="radio"/> Japanese	<input type="radio"/> Chinese	<input type="radio"/> Italian	<input type="radio"/> Hindi
<input type="radio"/> Portuguese	<input type="radio"/> Russian	<input type="radio"/> French	<input type="radio"/> Guatemalan	<input type="radio"/> Tagalog	<input type="radio"/> Arabic
<input type="radio"/> Bosnian	<input type="radio"/> Vietnamese	<input type="radio"/> Laotian	<input type="radio"/> German	<input type="radio"/> Gujarati	

INSURANCE INFORMATION

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
 DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
 INSURANCE COMPANY _____
 GROUP NUMBER _____ POLICY NUMBER _____
 CLAIMS MAILING ADDRESS: _____
 (usually found on back of card) _____

SECONDARY INSURANCE INFORMATION (if applicable)

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
 DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
 INSURANCE COMPANY _____
 GROUP NUMBER _____ POLICY NUMBER _____
 CLAIMS MAILING ADDRESS: _____
 (usually found on back of card) _____

PATIENT NAME (please print) _____ DATE OF BIRTH _____



SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ MARITAL STAU _____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY

NAME _____ LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

LabCorp Other (specify): _____

LIVING WILL

Do you have a living will?

<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I'd like information about establishing a living will
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PATIENT SIGNATURE _____ DATE _____

PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.

The HIPAA Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We are required to abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All of the providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.

Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.

Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.

Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must comply with HIPAA guidelines.

Disclosures Required by Law and Workers Compensation: We are permitted to disclose your health information to comply with workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.

Abuse or Neglect: We may disclose your protected health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.

Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.

Research and Health Oversight: We are permitted to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are permitted to disclose your health information to a health oversight agency for activities authorized by law. Examples include: audits, investigations, and inspections.

Written Authorization: Unless not required by law, your written authorization will be required for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.

Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information regarding the patient. If there is not appropriate identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment of your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.



OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____ **DATE** _____

OR SIGNED FOR PATIENT BY _____ **RELATIONSHIP** _____

DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

<input type="radio"/> I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message	<input type="radio"/> I choose to opt-out of voicemail messages.
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You also have my permission to disclose information about my care to the following individual(s): _____

PATIENT SIGNATURE _____ **DATE** _____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE (for pregnant patients only)

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____ **DATE** _____



HIV TESTING IN PREGNANCY (for pregnant patients only)

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing and understand that the result will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

DRUG TESTING IN PREGNANCY (for pregnant patients only)

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing and understand that the results will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

NO SHOW FEE

We understand that there are times when you may miss an appointment due to emergency or unexpected obligations for work or family, however, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient from getting an appointment. If an appointment is not cancelled at least 24 hours in advance, you may be charged a \$25 fee. This fee will not be covered by your insurance company.

PATIENT SIGNATURE _____ DATE _____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____ DATE _____

AABC PERINATAL DATA REGISTRY (for pregnant patients only)

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____



DISPLAY NAME AND DUE DATE ON BULLETIN BOARD CONSENT

Some parents choose to display their first name and due date (as well as baby's name, date of birth and weight after delivery) on our bulletin board. The HIPAA privacy law requires that our office have written consent to display this information at our facility. HIPAA also requires that we allow you to choose an expiration date at which time your information will be removed from display.

- I give permission to have my name, due date, baby's name, date of birth, and weight displayed on the bulletin board. It will be taken off display and provided to me at my six week postpartum visit (or destroyed)

- I do not give the birth center permission to display information about me or my baby

SIGNATURE _____ DATE _____

PHOTO DISPLAY CONSENT

Some parents choose to send us photographs of their babies to display on the bulletin board. The HIPAA privacy law requires that our office have written consent to display any photographs that you send to our facility. HIPAA also requires that we allow you to choose an expiration date at which time your photograph will be removed from display and discarded.

- I give permission to have any pictures I send to the birth center displayed on the bulletin board indefinitely

- I do **not** give the birth center permission to display any photos I may send

- I give permission to have any pictures I send to the birth center displayed on the bulletin board **until the following date** : _____

SIGNATURE _____ DATE _____

PRINT NAME _____



OB HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please complete **ENTIRE** form.

Name (<i>Last, First, M.I.</i>):		DOB:	
Marital status:		<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Significant other's name:		He/She is <input type="checkbox"/> present for pregnancy <input type="checkbox"/> deployed <input type="checkbox"/> incarcerated	
Is this pregnancy planned or unplanned?		Do you have supportive family and friends?	
Highest level of education:		Employment: What is your job?	
Who do you live with?			
What are your living arrangements? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other			
PERSONAL MEDICAL AND SURGICAL HISTORY:			
Please complete this portion of your health history in the <i>patient portal PRIOR</i> to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information. <u>If the patient portal is not completed, we may be required to reschedule or have you return for an additional visit to complete the appointment.</u>			
FAMILY HEALTH HISTORY:			
Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the <i>patient portal PRIOR</i> to your appointment.			

OB/GYN HEALTH HISTORY			
Last Menstrual Period:			
Last pap test:		Have you ever had an abnormal Pap test?	
Age period began?		Length of periods?	#days between periods?
Any recent changes in your periods?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sexually active?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use birth control?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you do regular self-breast exams?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Since your last period, have you had any illnesses, rash, fever or exposure to x-rays or toxic chemicals?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you born premature (<37 weeks)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently breast feeding another baby?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a UTI (urinary tract infection) within 6 months of this pregnancy		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced any of the following (check all that apply): <input type="checkbox"/> NONE			
<input type="checkbox"/> Sexual or physical abuse or assault		<input type="checkbox"/> Domestic violence	
<input type="checkbox"/> Emotional Abuse		<input type="checkbox"/> Childbirth trauma	
<input type="checkbox"/> Major accident or illness or other traumatic event			



Name: _____

Pregnancy History Total # pregnancy: ____ # Premature births ____ #miscarriages/ abortions: ____ # term births? _____

LAST NAME:						DOB:
Baby date of birth day/month/year	Weight	Sex	Weeks pregnant	Type of birth	Length of labor	Complications/ Comments

NUTRITION & EXERCISE

Exercise	Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> What type of exercise do you enjoy? _____	How often? _____
Diet	Are you on any special diet or have dietary restrictions? If so what? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you eat three meals a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a working stove?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have running hot and cold water?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you receive WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you able to purchase the foods you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like to speak to someone about your diet and foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
#meals you eat in an average day?	How much water a day? _____	How much caffeine a day? _____

How often do you eat:	Never	2-3 times/month	Once/week	2-3 times/week	Once/day	2-3 times/day
Fast/restaurant food						
Frozen meals						
Home-cooked meals						
Beef						
Chicken/Turkey						
Pork						
Fish, Type?						
Deli meat						
Beans						
Cookies/Cakes/Muffins						
Other refined grains (white bread, white rice, white pasta)						
Whole grains						
Vegetables (fresh, frozen)						
Fruit (Fresh, frozen)						
Canned vegetables/fruit						
Dairy (milk yogurt, cheese, butter)						
Fried food						
Artificial sweetener						
Meal replacement bars or shakes						

NAME: _____

Genetic Screening:

Comments

Are you older than 35 at the time of birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Family history of thalassemia (Italian Greek, Mediterranean or Asian)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of Neural tube defect (meningomyelocele, spina bifida)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Congenital heart defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Downs Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tay-sachs (Ashkenazi Jewish, Cajun, French-Canadian)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Canavan Disease (Ashkenazi Jewish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Familial dysautonomia (Ashkenazi Jewish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sickle cell disease or trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hemophilia or other blood disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Muscular dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Huntington Chorea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental retardation or autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other inherited genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Maternal metabolic disorder (diabetes type 1 or PKU)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
You or baby's father had a child with birth defects not listed above	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Recurrent pregnancy loss or stillbirth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medications including supplements, vitamins, herbs, illicit drugs, recreational drugs or alcohol or exposure to toxic chemicals or X-rays since last menstrual period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Infection history:

Comments:

Do you live with someone with TB or exposed to TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had chicken pox or had the vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had the HPV vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you or your partner have a history of herpes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a rash or viral illness since your last period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a history of Hepatitis B or C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a history of STDs (gonorrhea, chlamydia, HPV, HIV or syphilis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Reviewed by: _____ Date: _____

Name: _____

Date of Birth: _____

Edinburgh Pre/Postnatal Depression Scale¹ (EPDS)

As you are pregnant, or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt in the PAST 7 DAYS, not just how you feel today.

Here is an example:

I have felt happy

- Yes, all the time
- Yes, most of the time
- No, not very often
- No, not at all

This would mean, "I have felt happy most of the time," during the past week.

Please complete the questions below the same way.

In the past 7 days:

- | | |
|---|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I always could <input type="radio"/> Not quite so much now <input type="radio"/> Definitely not so much now <input type="radio"/> Not at all | <p>6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time I haven't been able to cope at all <input type="radio"/> Yes, sometimes I haven't been coping as well as usual <input type="radio"/> No, most of the time I have coped quite well <input type="radio"/> No, I have been coping as well as ever |
| <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I ever did <input type="radio"/> Rather less than I used to <input type="radio"/> Definitely less than I used to <input type="radio"/> Hardly at all | <p>7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, sometimes <input type="radio"/> Not very often <input type="radio"/> No, not at all |
| <p>3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, some of the time <input type="radio"/> Not very often <input type="radio"/> No, never | <p>8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, quite often <input type="radio"/> Not very often <input type="radio"/> No, not at all |
| <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="radio"/> No, not at all <input type="radio"/> Hardly ever <input type="radio"/> Yes, sometimes <input type="radio"/> Yes, very often | <p>9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, quite often <input type="radio"/> Only occasionally <input type="radio"/> No, never |
| <p>5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, quite a lot <input type="radio"/> Yes, sometimes <input type="radio"/> No, not much <input type="radio"/> No, not at all | <p>10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, quite often <input type="radio"/> Sometimes <input type="radio"/> Hardly ever <input type="radio"/> Never |

Administered/Reviewed by: _____ Date: _____

¹Source Cox, J L, Holden, J M and Sagovsky, R 1987. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786

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Date: _____

Name: _____

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs (excluding alcohol and tobacco) during the past 12 months. Carefully read each statement and decide if your answer is “no” or “yes,” then fill in the appropriate box beside the question.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter in excess of the directions, and any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents (e.g., paint thinners), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember, the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| 1. Have you used drugs other than those required for medical reasons? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Do you abuse more than one drug at a time? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. Are you always able to stop using drugs when you want to? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. Have you had “blackouts” or “flashbacks” as a result of drug use? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. Do you ever feel bad or guilty about your drug use? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. Does your partner (or parents) ever complain about your involvement with drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. Have you neglected your family because of your use of drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

----- *for office use only* -----

DAST Score: _____

Plan of Care: _____

Reviewed by: _____

Skinner, H.A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, 7, 363-371

Hurt, Insulted, Threatened with Harm and Screaming (HITS)

Domestic Violence Screening Tool

Name: _____ Date: _____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you?					
2. Insult or talk down to you					
3. Threaten you with harm?					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Reviewed by: _____

Each item is score from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse and should seek counseling or help from a domestic violence resource center.

Sherin, K. et.al. *HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting*, Family Medicine 1998;30(7):508-12.)

National Hotlines can connect clients to local resources and provide support.

For Free help 24 hours a day, call:

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224

Teen Dating Abuse Hotline

1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)

1-800-656-HOPE (1-800-656-4673)

Georgia 24 Hour Statewide Domestic Violence Hotline

1-800-33HAVEN (1-800-334-2836) <https://gcadv.org/get-help/>

