

Unicare Community Health Center Patient Registration

UCHC/Pt. Reg., May 2020

Patient Name: _____
Last
First
Middle

Address: _____
Street
Apt. #
City
Zip

Phone #: (____) _____ (____) _____ (____) _____
Home
Work
Cellular

Do you have a **Social Security Number?** Yes No Social Security Number: _____

Is your Social Security # for employment only? Yes No Email Address: _____

Date of Birth: _____ Age: _____ Sex: Male Female
Month / Day / Year

Homeless? Yes No

Living Situation: Own Rent Motel/Hotel Car/Vehicle Halfway House/Shelter Homeless Shelter
 Transitional Street Permanent Supportive Housing Other **Are you a Veteran?** Yes No

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Are you disabled? Yes No **Smoke?** Yes No **Sexual orientation:** Lesbian/Gay Straight
 Bisexual Do not wish to disclose

Ethnicity: Non-Latino/ Hispanic Latino/ Hispanic **Race:** White Asian African American American Indian Pacific Islander
 Native Hawaiian More than 1 race Refuse to report

Gender Identity: Male Female Transgender Male Transgender Female Do not wish to disclose

Education level completed: Less than high school graduate Some College/Associate degree
 High school graduate Bachelor's degree or higher

Are you an agricultural worker? Yes No **If yes, are you seasonal or migrant?** Seasonal Migrant **Is one of your family members an agricultural worker?** Yes No **If yes, which type?** Seasonal Migrant

Number of people in your family household: _____ **Annual family income:** \$ _____

What language should your information be provided in? _____

How well do you understand English? Very well Moderate Very little None

Do you have any allergies? _____

Friend or Relative to Contact In Case of Emergency: _____
(Name)
(Relationship)
(Telephone #)

If minor, mother's name: _____ If minor, father's name: _____

How did you hear of the Clinic UCHC? _____

- | | | |
|---|--|--|
| 1. Do you have health insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, with what company are you insured? _____ |
| 2. Do you have dental insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, with what company are you insured? _____ |
| 3. Do you have Medi-Cal? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Policy #: _____ |
| 4. Does your child (patient) have CHDP? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Do you have FPACT? <input type="checkbox"/> Yes <input type="checkbox"/> No |

I understand that health information is confidential. I authorize the exchange of information between UCHC and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available upon request. I authorize to receive any and all services provided by UCHC, including but not limited to: Primary Care, Dental, Behavioral, Substance Use and Psychiatric services.

I hereby authorize treatment by UCHC. Yes No Initials _____

The exchange of information may include treatment for:
 Alcohol or drugs- Yes No Initials _____ Psychiatric drugs- Yes No Initials _____

Adequate numbers of radiographs are required for proper diagnosis. Yes No Initials _____
 I consent to performing radiographs as needed for my dental treatment: _____

Patient Signature or guardian (if minor): _____ **Date** _____

Name and relationship (if not patient) _____



MISSION STATEMENT / *DECLARACION DE MISSION:*

The mission of Unicare is to be a community health care organization that treats everyone with dignity, respect and cultural sensitivity to help create an environment in which all can prosper.

La misión de Unicare es ser una organización de salud comunitaria que trata a todos con dignidad, respeto y sensibilidad cultural para ayudar a crear un ambiente en el que todos puedan prosperar.

**NOTICE OF PRIVACY PRACTICES
NOTIFICACIÓN DE PRACTICAS DE PRIVACIDAD**

I hereby acknowledge that a copy of Unicare Community Health Center, Inc.'s "Notice of Privacy Practices." is posted in the waiting area and I further understand that I can request a copy at any time if I wish in the language that I prefer.

Recibí una copia de la "Notificación de Prácticas de Privacidad" de Unicare Community Health Center, Inc. Reconozco que una copia de la "Notificación de la Privacidad" se puede encontrar en la sala de espera, y además entiendo que puedo solicitar una copia en cualquier idioma en el momento que deseo.

PATIENT NAME/*NOMBRE DEL PACIENTE*

DATE OF BIRTH/*FECHA DE NACIMIENTO*

SIGNATURE OF PATIENT OR LEGAL GUARDIAN/*FIRMA DEL PACIENTE O TUTOR LEGAL*

DATE/*FECHA*



UNICARE COMMUNITY HEALTH CENTER, INC.
ACKNOWLEDGEMENT/ RECONOCIMIENTO

PATIENT NAME / NOMBRE DEL PACIENTE

DOB / FECHA DE NACIMIENTO

ADDRESS / DIRECCIÓN

CITY / CIUDAD

STATE / ESTADO

ZIP CODE / CÓDIGO POSTAL

TELEPHONE / NO. DE TELÉFONO

ADVANCE DIRECTIVE / DIRECTIVA ANTICIPADA

I acknowledge that the physician or one of his / her staff members have provided me with information regarding Advance Directive.

Reconozco que el médico o uno de sus miembros del personal me han proporcionado información con respecto a la Directiva Anticipada.

1. I am 18 years old or older. (Check one) YES / SI NO

1. Tengo 18 años o más. (Marque uno)

2. I realize that I have the option of putting together Advance Directive for my healthcare. My physician has provided me with written information concerning Advance Directive. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advance Directive.

2. Reconozco que tengo la opción de elaborar una directiva anticipada para mi atención médica. Mi médico me ha proporcionado información por escrito sobre la Directiva Anticipada. Entiendo que es mi responsabilidad proporcionar a mi (s) doctor (es) con cualquier documento que se requiera para llevar a cabo mi Directiva Anticipada.

3. I am aware that Advance Directive may be one of the following:

3. Estoy consciente de que la Directiva Anticipada puede ser una de las siguientes:

- a) A Durable Power of Attorney for healthcare.
a) Un Poder Notarial Duradero para el cuidado de la salud.
- b) The Declaration in the A Natural Death Act – Ex. A Living Will.
b) La Declaración en la Ley de muerte natural - Ex. Un Testamento Vital.
- c) I may write down my wishes on a piece of paper, so that my family may use the document in deciding my medical treatment in the event I am unable to do so.
c) Puedo anotar mis deseos, para que mi familia pueda usar el documento para decidir mi tratamiento médico en caso de que yo no pueda hacerlo.

PATIENT SIGNATURE / FIRMA DEL PACIENTE

DATE / FECHA

THIS DOCUMENT WILL BECOME PART OF MY MEDICAL RECORD.
ESTE DOCUMENTO SE HARÁ PARTE DE MI REGISTRO MÉDICO.



ADULT HEALTH HISTORY:

Name/Nombre:	Age/Edad:	D.O.B./Cuando Nacio:	Date/Fecha:
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HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion.....	No	Yes/Si	Rheumatic fever/Fiebre Reumatica.....	No	Yes/Si
Mumps/Paperas.....	No	Yes/Si	Heart Disease/Enfermedad del Corazon.....	No	Yes/Si
Chickenpox/Viruela.....	No	Yes/Si	Tuberculosis.....	No	Yes/Si
Diabetes.....	No	Yes/Si	Venereal Disease/Enfermedad Veneria.....	No	Yes/Si
Strokes/Embolio.....	No	Yes/Si	Serious Disease/Enfermedad Graves.....	No	Yes/Si

Ever hospitalized/Ha sido hospitalizado..... No Yes/Si Explain/Explicacion _____
 Ever had surgery/Ha tenido operaciones..... No Yes/Si Explain/Explicacion _____
 Had broken bones/Ha tenido fracturas..... No Yes/Si Explain/Explicacion _____
 Head concussions or injuries/Glopes o Heridas de cabeza..... No Yes/Si Explain/Explicacion _____

Date of Last Tetanus Shot/La Fecha de su ultima inmunizacion de Tetno _____

Date of Last PAP Smear/La Fecha de papanicolou exam de cancer _____

Date of Last Mammogram/Mammographia _____

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer.....	No	Yes/Si	Who/Quien? _____
Diabetes.....	No	Yes/Si	Who/Quien? _____
Tuberculosis.....	No	Yes/Si	Who/Quien? _____
Heart trouble/Enfermedad del Corazon.....	No	Yes/Si	Who/Quien? _____
High blood pressure/Presion alta.....	No	Yes/Si	Who/Quien? _____
Stroke/Embolio.....	No	Yes/Si	Who/Quien? _____
Convulsions/Epilepcia.....	No	Yes/Si	Who/Quien? _____
Suicide/Suicidio.....	No	Yes/Si	Who/Quien? _____

SOCIAL HISTORY/HISTORIA SOCIAL:

Single/Soltero Married/Casado Separated/Separado Divorced/Divorciado Widowed/Viudo

Alcoholic Beverages/Bebidas Alcoholicas: Never/Nunca How much/Cuanto _____

Tobacco or Cigarettes/Tobacco o Cigarillos: Never/Nunca How much/Cuanto _____

Are you sexually active?/Este sexualmente activa? Yes No

What is your job?/Cual es su trabajo? _____

Education Level/Nivel de Education: 1 2 3 4 5 6 7 8 9 10 11 12 College/Colegio Supenor: 1 2 3 4

Race/Raza: Asian Native Hawaiian Other Pacific Islander American Indian White
African American More than 1 Race Other

Ethnicity/Etnicidad: Hispanic/Latino Not Hispanic/Latino

Primary language (lenguaje primario) _____ Secondary language (lenguaje secundaria) _____

SYSTEMIC REVIEW GENERAL? REVISION DE SISTEMAS:

Recent weight change?/Reciente cambio de peso?..... No Yes/Si
 Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?..... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel.....	No	Yes/Si	Explain/Explicacion _____
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nanz-Garganta.....	No	Yes/Si	Explain/Explicacion _____
Neck/Cuello.....	No	Yes/Si	Explain/Explicacion _____
Lungs/Pulmones.....	No	Yes/Si	Explain/Explicacion _____
Heart and Circulation/Corazon o Circulacion....	No	Yes/Si	Explain/Explicacion _____
Blood/Sangre.....	No	Yes/Si	Explain/Explicacion _____
Emotions/Emociones.....	No	Yes/Si	Explain/Explicacion _____
Nerves/Nervios.....	No	Yes/Si	Explain/Explicacion _____
Muscles and Bones/Estomago o Intestinos.....	No	Yes/Si	Explain/Explicacion _____
Sex Organs/Organos Sexuales.....	No	Yes/Si	Explain/Explicacion _____
Urinary/Unnanos.....	No	Yes/Si	Explain/Explicacion _____
Any other/Cualquiera otro.....	No	Yes/Si	Explain/Explicacion _____

ALLERGIES OR REACTIONS TO FOOD/MEDICATION/LATEX? (ALERGIAS O REACIONES A ALIMENTOS/MEDICINAS/LATEX?)

If applicable, list all current medications (lista de medicamentos actuales) _____

PATIENT SIGNATURE/FIRMA _____ DATE/FECHA _____

DOCTOR SIGNATURE/FIRMA _____ DATE/FECHA _____



UNICARE COMMUNITY HEALTH CENTER

ADULT TUBERCULOSIS RISK ASSESSMENT

EVALUACIÓN DE RIESGO DE TUBERCULOSIS PARA ADULTOS

You may be at increased risk for TB if you answer YES to any of the following questions:
Usted puede estar en mayor riesgo de TB si responde SÍ a cualquiera de las siguientes preguntas:

DATE / FECHA
/ /

- | | | |
|--|--------------------------------------|--------------------------------|
| 1. Do you have a family member or close contact with history of confirmed or suspected TB?
<i>¿Tiene un familiar o un contacto cercano con historial médico de TB confirmada o sospechada?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.)
<i>¿Es usted de Asia, de África, de Centroamérica o de Suramérica? (Estas áreas tienen una mayor prevalencia de TB).</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 3. Do you live in an "out of home" placement facility?
<i>¿Vive en una instalación de colocación "fuera de casa"?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 4. Do you have a history of confirmed or suspected HIV infection?
<i>¿Tiene historial médico de infección por VIH confirmada o sospechada?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 5. Do you live with any individual who is HIV positive?
<i>¿Vive usted con alguna persona que sea VIH positivo?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years?
<i>¿Ha estado, o vive con algún individuo que ha estado encarcelado en los últimos 5 años?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home?
<i>¿Vive usted o está frecuentemente expuesto a personas sin hogar, trabajadores agrícolas migratorios, usuarios de drogas de la calle o residentes en un asilo de ancianos?</i> | YES / SI
<input type="checkbox"/> | NO
<input type="checkbox"/> |

*A person who is at increased risk for TB should have a yearly TB test.

* Una persona que está en mayor riesgo de tuberculosis debe tener una prueba anual de TB.

NAME / NOMBRE

DATE / FECHA

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form <i>(if patient needs help)</i>	<input type="checkbox"/> Family Member <input type="checkbox"/> Other <i>(Specify)</i>	<input type="checkbox"/> Friend	Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
 Yes No

<i>Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.</i>					Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Clinic Use Only:</i>					Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	Safety
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: <input type="checkbox"/> (men) 5 or more alcohol drinks in one day? <input type="checkbox"/> (women) 4 or more alcohol drinks in one day?	No	Yes	Skip	Sexual Issues
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Other Questions
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature:		Print Name:		Date:	
SHA ANNUAL REVIEW					
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form (<i>if patient needs help</i>) <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other (<i>Specify</i>)			Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
 Yes No

<i>Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.</i>					Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Clinic Use Only:</i>					Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	Physical Activity
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	Dental Health
17	Do you brush and floss your teeth daily?	Yes	No	Skip	
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Independent Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature:	Print Name:			Date:	
SHA ANNUAL REVIEW					
PCP's Signature:	Print Name:			Date:	
PCP's Signature:	Print Name:			Date:	
PCP's Signature:	Print Name:			Date:	
PCP's Signature:	Print Name:			Date:	