



612 W. 8th Street
Roswell, NM 88201
Phone: 575-623-6161
Fax: 575-623-6464
caloorfamilymedicalpractice@yahoo.com

Name: _____

Address: _____

City: _____ State: _____

Email Address: _____

_____ I agree to receive SMS (short message service) text and voicemail messaging for appointment reminders.

Cell Number: _____

Home Number: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship to patient: _____

PHARMACY: _____

Patient signature: _____ Date: _____

Health Questionnaire

Name: _____ DOB: ____/____/____

Reason for seeing the Dr. _____

Allergies to Medications

Other Allergies

Hospitalizations or surgeries

Date: _____ Surgery: _____ Reason for Surgery: _____

Medications Presently Taking

Name _____ Strength (MG, MCG ETC.) _____ How is this medication taken/how often _____

Habits

Alcohol: YES _____ NO _____ TYPE _____ Amount per day/week _____
Smoking: Yes _____ NO _____ Qty per day _____ How long _____ want to quit? _____
Salt Intake: High _____ Medium _____ Low _____ Fat Intake: High _____ Med _____ Low _____
Coffee: Yes _____ No _____ Cups per day _____ Other Caffeine _____ Amt per day _____
Exercise: Yes _____ No _____ Routine _____

Female Patients Please Complete

Hysterectomy: Yes _____ No _____ Date _____ Partial or Complete _____

Pregnant: _____ Planning to Become Pregnant: _____ How Soon _____

Menstrual Cycle (periods) Regular: _____ Irregular: _____ Pain/Cramps _____

Number of Days of flow: _____ Length of cycle: _____ Date of last period: _____

Pain or bleeding during or after sex: Yes _____ No _____

Number of pregnancies: _____ Abortions: _____ Miscarriages: _____ Live Births: _____

Birth Control Method: _____ Name of Medication: _____

Date of last Pap Smear: _____ Normal: _____ Abnormal: _____

Date of last Mammogram: _____ Normal: _____ Abnormal: _____

Comments: _____



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Narcotic Medication Policy

Our office policy is that we do not prescribe narcotic pain medication. If you have chronic pain that is not controlled with non-narcotic medications you will be referred to a pain specialist.

I, _____ have been informed of the above policy and understand that I will not be prescribed any narcotic pain medications.

Signature of patient/guardian

Date



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No Show Agreement

As a valued patient we want to give you the best medical care possible. We need your help to accomplish this by coming to your scheduled appointments. As of March 1, 2025, we will be charging a "NO SHOW" fee of \$40.00 for missed appointments without notice. This charge will be billed directly to you, not to your insurance carrier. You MUST give notice to cancel or reschedule prior to your appointment to avoid this fee.

This "NO SHOW" charge is to be paid prior to your next appointment in order to be seen.

After 3 "NO SHOW" appointments or non-payment of "NO SHOW" fees you will be dismissed from this clinic.

We appreciate your understanding and cooperation in this matter.

I, _____, have read and agree to adhere to the above policy.

Patient/guardian signature

Date

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date					
<p>Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.</p>		Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
Part A						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking too much when you are in social situations?						
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
Part B						

MOOD DISORDERS QUESTIONNAIRE (MDQ)

1. Has there ever been a period of time when you were not your usual self and
-you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? Yes No
-you were so irritable that you shouted at people or started fights or arguments? Yes No
-you felt much more self-confident than usual? Yes No
-you got much less sleep than usual and found you didn't really miss it? Yes No
-you were much more talkative or spoke faster than usual? Yes No
-thoughts raced through your head or you couldn't slow your mind down? Yes No
-you were so easily distracted by things around you that you had trouble concentrating or staying on track? Yes No
-you had much more energy than usual? Yes No
-you were much more active or did many more things than usual? Yes No
-you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? Yes No
-you were much more interested in sex than usual? Yes No
-you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? Yes No
-spending money got you or your family into trouble? Yes No
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? Yes No
3. How much of a *problem* did any of these cause you -- like being unable to work; having family, money, or legal troubles; getting into arguments or fights? Yes No

No problem

References

Hirschfeld RM, Williams JB, Siltzer RL, et al.

"Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: the Mood Disorder Questionnaire." *Journal of Clinical Psychiatry*, 2000, 157(11):1873-6

Mulrow CD, Williams JW Jr, Carey MB, et al.

"Case-Finding Instruments for Depression in Primary Care Settings." *Ann Intern Med*, 1995, 122(12):913-21.

Minor problem

Moderate problem

Serious problem



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Acknowledgement of Notice of Privacy Practices

I have been present with a copy of the Notice of Privacy Practices for the office of Seyed Hassan Nazirpour-Caloor DNP, FNP, BC, AANP, detailing how my information may be used and disclosed as permitted under federal and state law.

Signature of patient

Date

If not signed by patient above please indicate your relationship to the patient (e.g. mother) and patient's name:

Patient Name: _____
Relationship to patient: _____

CUDOS-M Questionnaire

CUDOS-M=Clinically Useful Depression Outcome Scale supplemented with questions for the DSM-5 mixed features specifier.

Instructions

This questionnaire includes questions about symptoms some patients have. For each item, please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

Rating Guidelines

0 = not at all true (0 days) 1 = rarely true (1-2 days) 2 = sometimes true (3-4 days)
3 = often true (5-6 days) 4 = almost always true (every day)

During the PAST WEEK, INCLUDING TODAY...

- | | | | | | | | | | | | | | |
|----|---|---|---------------|---|---|---|----|--|---|---|---|---|---|
| 1 | I felt sad or depressed | 0 | 1 | 2 | 3 | 4 | 17 | I felt so happy and cheerful it was like a high | 0 | 1 | 2 | 3 | 4 |
| 2 | I was not as interested in my usual activities | 0 | 1 | 2 | 3 | 4 | 18 | I had many brilliant, creative ideas | 0 | 1 | 2 | 3 | 4 |
| 3 | My appetite was poor and I didn't feel like eating | 0 | 1 | 2 | 3 | 4 | 19 | I felt extremely self-confident | 0 | 1 | 2 | 3 | 4 |
| 4 | My appetite was much greater than usual | 0 | 1 | 2 | 3 | 4 | 20 | I slept only a few hours but woke full of energy | 0 | 1 | 2 | 3 | 4 |
| 5 | I had difficulty sleeping | 0 | 1 | 2 | 3 | 4 | 21 | My energy level seemed endless | 0 | 1 | 2 | 3 | 4 |
| 6 | I was sleeping too much | 0 | 1 | 2 | 3 | 4 | 22 | I was much more talkative than usual | 0 | 1 | 2 | 3 | 4 |
| 7 | I felt very fidgety, making it difficult to sit still | 0 | 1 | 2 | 3 | 4 | 23 | I spoke faster than usual | 0 | 1 | 2 | 3 | 4 |
| 8 | I felt physically slowed down, like my body was stuck in mud | 0 | 1 | 2 | 3 | 4 | 24 | My thoughts were racing through my mind | 0 | 1 | 2 | 3 | 4 |
| 9 | My energy level was low | 0 | 1 | 2 | 3 | 4 | 25 | I took on many new projects because I felt I could do everything | 0 | 1 | 2 | 3 | 4 |
| 10 | I felt guilty | 0 | 1 | 2 | 3 | 4 | 26 | I was much more social and outgoing than usual | 0 | 1 | 2 | 3 | 4 |
| 11 | I thought I was a failure | 0 | 1 | 2 | 3 | 4 | 27 | I did wild, impulsive things | 0 | 1 | 2 | 3 | 4 |
| 12 | I had problems concentrating | 0 | 1 | 2 | 3 | 4 | 28 | I spent money more freely than usual | 0 | 1 | 2 | 3 | 4 |
| 13 | I had more difficulties making decisions than usual | 0 | 1 | 2 | 3 | 4 | 29 | I had many more thoughts and fantasies about sex | 0 | 1 | 2 | 3 | 4 |
| 14 | I wished I was dead | 0 | 1 | 2 | 3 | 4 | | | | | | | |
| 15 | I thought about killing myself | 0 | 1 | 2 | 3 | 4 | | | | | | | |
| 16 | I thought that the future looked hopeless | 0 | 1 | 2 | 3 | 4 | | | | | | | |
| 30 | Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week? | | | | | | | | | | | | |
| | 0 not at all | | 3 quite a bit | | | | | | | | | | |
| | 1 a little bit | | 4 extremely | | | | | | | | | | |
| | 2 a moderate amount | | | | | | | | | | | | |
| 31 | How would you rate your overall quality of life during the past week? | | | | | | | | | | | | |
| | 0 very good, my life could hardly be better | | | | | | | | | | | | |
| | 1 pretty good, most things are going well | | | | | | | | | | | | |
| | 2 the good and bad parts are about equal | | | | | | | | | | | | |
| | 3 pretty bad, most things are going poorly | | | | | | | | | | | | |
| | 4 very bad, my life could hardly be worse | | | | | | | | | | | | |

Remember to talk about your responses to this questionnaire with your healthcare provider.





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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information and it also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please ask your physician or contact our Privacy Officer listed above.

A. How this medical practice may use or disclose your health information.

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes.

- 1. TREATMENT:** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory to perform a test. We may also disclose medical information to members of your family or others who can help you when you are sick, injured or following your death.
- 2. PAYMENT:** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided you.
- 3. Deny your request to access your psychotherapy notes. You will have the right to have them transferred to another mental health professional.**

4. Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, (unless the person or entity that created the information is no longer available to make the amendment) If you would not be permitted to inspect or copy the information at issue or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 205 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2. (payment), 3. (health care operations), 4. (notice and communication), with family and specialized government functions of section A of this notice of privacy practices or disclosures for purposes of research or public health, which exclude direct patient identifiers, or which are incident to a use of disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonable likely to impede their activities.

6. You have the right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this notice of privacy practices, even if you have requested its receipt by email. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of more of these rights, contact our privacy officer listed above.

We reserve the right to amend our privacy practices and the terms of this notice of privacy practices at any time in the future, until such amendment is made, we are required by law to comply with the notice. After an amendment is made, the revised notice of privacy protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current posted in our reception area, and a copy will be available at each appointment upon request.

Release of Information

All portions of this form must be completed to constitute a valid authorization for release of health information under the health insurance portability accountability act (HIPPA) privacy regulations if any field is left blank, the authorization will be considered defective.

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

I authorize the use and disclosure of health information about me as described below

Facility authorized to release my Health information:

Name of Facility: _____

Address and Phone: _____

Agency or Individuals authorized to receive my health information:

Caloor's Family Medical Practice

612 W. 8th Street

Roswell, NM 88201

Health information that may be used/ or disclosed is limited to the following: (Please check all that apply)

- Discharge summary consultation Pathology Report Labs
- History and Physical Operative notes Imaging/X-Rays Entire Medical record
- Other (please specify) _____

Health information that may be used and /or disclosed is limited to the following

All Specify _____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purposes: (including research or marketing if appropriate)

Medical Other (specify) _____

Health information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to is medical records, x-rays in any form. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herin, to include substance abuse, communicable diseases, including HIV status, and/or psychiatric diagnosis compiled during my visits, encounters or hospitalizations, or make copies there of in accordance with the with the policies of the facility. I understand further use of disclosure of the authorized information by the above name/agency or individual may not be accomplished without further written authorization. If research related health information is used or disclosed for continued research purposes, an expiration date does not apply.



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This authorization will automatically expire in 60 days after the date below (except indicated above), unless an earlier date is specified, or at the conclusion of the specified event. I understand that I have the right to revoke this authorization at any time, in writhing as stated in the notice of privacy practices, except where the facility has already disclosed in reliance upon my prior authorization, treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorizations may result in denial or care coverage.

Notice to receiving agency or individual. This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Patients Signature or Authorized Party: _____

Date: _____ Time: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____

*** THERE IS A CHARGE FOR PRINTING MEDICAL RECORDS*** _