AlphaStaff
Simplifying business. Benefiting people.

Personal Health Questionnaire (PHQ)

Employee Name: _____ Employer Name: _____
Daytime Phone: _____ Date of Hire: _____

Are you planning to enroll in your employer's health insurance plan? YES ☐ NO ☐

If "YES", please select level of coverage intended:

- ☐ EE Employee Only
- ☐ ES Employee and Spouse
- ☐ EC Employee and Child(ren)
- ☐ EF Family

If "NO", please provide reason:

- ☐ Covered by Spouse's Plan
- ☐ Covered by Medicare Plan
- ☐ Other Reason: _____
- ☐ Not Eligible
- ☐ Do not want coverage

If you have selected "Yes," please complete the rest of the form.

If you have selected "No," skip the remainder and sign at the bottom.

· *Please answer the following questions for yourself* ***and eligible enrolling family members.***

· *Incomplete forms may delay the effective date of coverage.*

I. Demographic Chart

#	Relation to Employee	Member Name	Gender (M/F)	DOB (mm/dd/yyyy)	Home ZIP Code	Height FT.	Height IN.	Weight (lbs)	Tobacco use in last year? (Yes/No)
1	Employee								
2	Spouse								
3	Child								
4	Child								
5	Child								
6	Child								

II. Medical Conditions & Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hosptialized for any of the following?

*** Check "YES" or "NO" for each question. Please complete **ADDITIONAL DETAIL TABLE on p.3 for ALL "YES" answers.**

1. Cancer (if yes, location and type of cancer below) Yes ☐ No ☐

Check one: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ higher

Location and type of cancer _____

Date of remission (if applicable):

2. Cardiac or Heart Disease / Disorder Yes No Yes ☐ No ☐

if yes, check all that apply:

☐ heart attack,

☐ bypass surgery or angioplasty on **single** vessel, or

☐ bypass surgery or angioplasty on **multiple** vessels;

☐ **other (list here):**_____

such as: abnormal heart rhythms, aneurysm, aortic dissection, heart failure (congestive or otherwise), heart valve disorder, or peripheral arterial disease

II. Medical Conditions & Treatments (continued)

3. Diabetes (if yes, list type 1 or 2) **Yes No** Yes ☐ No ☐

Type: _____

List 3 most recent HbA1c / fasting blood sugar levels:

1) _____ **2)** _____**3)** _____

4. High Cholesterol (if yes, list 3 most recent readings) **Yes No** Yes ☐ No ☐

1) _____ **2)** _____**3)** _____

5. High Blood Pressure (if yes, 3 most recent readings) **Yes No** Yes ☐ No ☐

1) _____ **2)** _____**3)** _____

6. AIDS or HIV+ Yes ☐ No ☐

7. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout) Yes ☐ No ☐

8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain) Yes ☐ No ☐

9. Benign Growth (i.e. tumor, cyst) Yes ☐ No ☐

10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis) Yes ☐ No ☐

11. Circulatory System Disease Yes ☐ No ☐

12. Immune / Autoimmune Disease Yes ☐ No ☐

13. Kidney Disorder (i.e. nephritis, renal failure) Yes ☐ No ☐

14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E) Yes ☐ No ☐

15a. Mental Condition

a. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia) Yes ☐ No ☐

b. Are you currently receiving counseling? Type: _____ Yes ☐ No ☐

16. Muscular Disorder Yes ☐ No ☐

17. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis) Yes ☐ No ☐

18. Stomach (i.e. ulcer, acid reflux, GERD) Yes ☐ No ☐

19. Substance dependency (i.e. alcohol, drug) Yes ☐ No ☐

20. Transplants (if yes, list organ(s) below) Yes ☐ No ☐

_____

21. Is anyone currently taking **prescription medication(s)?**..... Yes ☐ No ☐

22. Has anyone had any of the following for a **serious illness in the past 5 years?**

a) treatment _____ Yes ☐ No ☐

b) hospitalization _____ Yes ☐ No ☐

c) surgery _____ Yes ☐ No ☐

23. Is anyone **currently**:

a) hospitalized or confined in a treatment facility? Yes ☐ No ☐

b) confined at home, incapacitated or incapable of self- support? Yes ☐ No ☐

II. Medical Conditions & Treatments (continued) Yes No

24. Is any of the following **pending?** Yes ☐ No ☐

a) treatment (medical treatment or diagnostic testing) _____

b) hospitalization _____

c) surgery _____

25. In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form? Yes ☐ No ☐

25. In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?.....

III. Pregnancy and Childbirth

26. Is anyone **pregnant?** (If no, mark "No" and skip question 26.) b) Yes ☐ No ☐

a) The due date is: _____

b) Are there any complications, including bleeding, with this pregnancy? Yes ☐ No ☐

c) Are multiple births expected? Yes ☐ No ☐

d) If so, please circle one: ☐ **Twins** ☐ **Triplets** ☐ **More**

ADDITIONAL DETAIL TABLE - PLEASE FILL IN DETAILS BELOW FOR ALL QUESTION(S) ANSWERED "YES".

Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug	Still taking? (Y / N)	Degree of Recovery

*** If you marked "Yes" for any responses in Sections II or III, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

In the event that information has been intentionally omitted or misrepresented, the insurance carrier may deny or limit coverage, furthermore, the AlphaStaff service agreement may terminate for breach. In such cases, I understand that AlphaStaff or the carrier may change my insurance premiums. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

AlphaStaff gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for GINA, AlphaStaff is not requesting genetic information.

AlphaStaff Program Notice of Privacy Practices provides more detailed information about how AlphaStaff Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The AlphaStaff Program and my health plan are not required by law to grant my request. However, if my request is granted, the AlphaStaff Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the AlphaStaff Program or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify AlphaStaff of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Employee SIGN HERE and Date:

X: _____ Date: _____