Kenton Family Wellness Center ~ Confidential Intake Form

Name _____ Birth Date _____ Today's Date _____

Address _____ City, State, Zip _____

Phone (day) _____ (evening) _____

Is it ok to leave a message? ☐ Y ☐ N How did you hear about our office? _____

Email _____ Would you like to receive email updates and specials? ☐ Y ☐ N

Occupation _____ ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance – if applicable

Insurance Carrier _____ Plan Name _____

ID/Subscriber # _____ Group # _____

Primary on Policy? ☐ Y ☐ N, answer following for Primary Insured: Insured's ID # _____

Legal Name _____ DOB _____ Relationship to You _____

Secondary Insurance – if applicable

Insurance Carrier _____ Plan Name _____

ID/Subscriber # _____ Group # _____

Primary on Policy? ☐ Y ☐ N, answer following for Primary Insured: Insured's ID # _____

Legal Name _____ DOB _____ Relationship to You _____

Motor Vehicle or Work Accident Claims – if applicable

Insurance Carrier _____ Claim # _____ Claim Submitted? ☐ Y ☐ N

Date of Injury _____ In _____ State Adjuster's Name _____

Claims Address _____ Carrier or Adjuster Phone _____

Attorney's Name _____ Phone _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize Kenton Family Wellness Center to submit claims to my insurance carrier(s) or their intermediaries for all services rendered by Kenton Family Wellness Center and direct them to issue payment directly to Kenton Family Wellness Center. I understand I am responsible for all charges not covered by my insurance company.

_____ _____

Patient or Guardian Signature Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

LEGAL RESPONSIBILITIES OF KENTON FAMILY WELLNESS CENTER

As mandated by Federal and State legal requirements, your protected health information must be kept secure. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE

Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

TREATMENT

Use and disclosure of your protected health information may be provided to a physician or other healthcare provider (including those of Kenton Family Wellness Center) providing treatment to you. However, this information will not be provided unless you have requested so in writing.

PAYMENT

Your protected health information may be used and disclosed to obtain payment for services we provided to you.

HEALTHCARE PROCESSES

We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION

At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

PERSON INVOLVED IN CARE

In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

MARKETING HEALTH-RELATED SERVICES

The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

REQUIRED BY LAW

Your protected health information may be used or disclosed if required by law.

ABUSE OR NEGLECT

As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

NATIONAL SECURITY
Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

APPOINTMENT REMINDERS
Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, emails, or letters.

PATIENT RIGHTS

ACCESS
At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

DISCLOSURE ACCOUNTING
Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

RESTRICTIONS
You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

ALTERNATIVE COMMUNICATION
Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

AMENDMENT
You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

ELECTRONIC NOTICE
If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS
If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way.

I have read and understood the HIPAA privacy policies of Kenton Family Wellness Center

_____ _____

Patient or Guardian Signature Date

Health History

Below you will find a number of questions related to your health history. For your convenience, we have tailored this information to be applicable to all modalities available at our clinic. While not all of the questions may seem directly related to your main complaint or reason for seeking care, your answers to these questions will inform your treatment throughout the course of your care at Kenton Family Wellness Center. Therefore, we ask you to be as thorough and thoughtful as possible as you consider the questions below.

What is the main issue you would like to address in your treatment?

When did this issue begin?

What was the cause of the condition? (if known)

Is it getting worse? ☐ Yes ☐ No Is it aggravated by: ☐ Standing ☐ Sitting ☐ Driving ☐ Stress

How does this problem interfere with your daily activities? (sleep, work, other)

Have you consulted a primary care physician? Y N If yes, did they provide you with a diagnosis?

What other treatments have you tried and what were the outcomes?

What are other health concerns you have today?

Name of Your Primary Care Physician: _____ Phone: _____

Seen for what condition? _____ Date of Last Visit: _____

I hereby authorize Kenton Family Wellness Center to contact my primary care physician, as needed:

_____ _____
Signature Date

Diagnostics

Which diagnostic studies have you had in the past **year**?

☐ Electrocardiogram (EKG) ☐ X-Ray ☐ Bone Density Scan (DEXA) ☐ Electroencephalogram (EEG)
☐ Mammogram ☐ CT Scan ☐ Blood Drawn ☐ MRI ☐ Other: _____

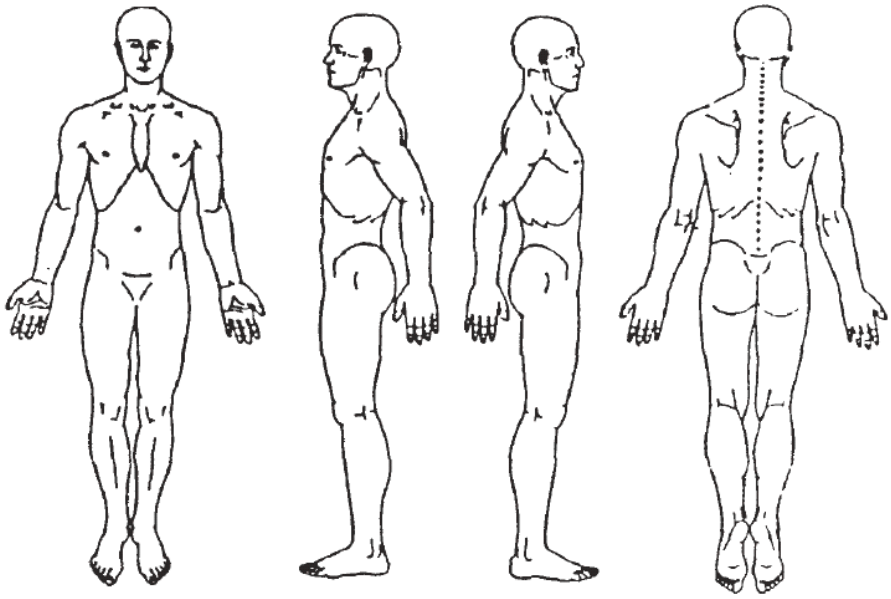
Was a condition diagnosed as a result?

Musculo-Skeletal Pain

Please indicate any areas of pain or discomfort:

Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✻ = sharp/stab
ooo = numb/tingle
⟶ = shooting
//// = stiff/tight



DO YOU HAVE ANY OF THE FOLLOWING?

☐ Generalized muscle pain or stiffness ☐ Swollen, painful, stiff joints ☐ Bone pain ☐ Tremors, twitches
☐ Numbness or tingling ☐ Loss of strength ☐ Hernia ☐ Breast Implants ☐ Other _____

Current Medications

Do you take or use?

☐ Laxatives ☐ Pain relievers ☐ Antacids ☐ Sleep Aids
☐ Cortisone ☐ Tranquilizers ☐ Hormones ☐ Oral Contraceptives ☐ Thyroid medication
☐ Antidepressants/anti-anxiety ☐ Coumadin ☐ Cholesterol medication ☐ Blood Pressure medication

If you take or use the following, please list (use back of page, if necessary):

Prescription Medications:

Vitamins/Supplements/Herbals/Homeopathics:

Over-the-Counter Medications:

Hospitalizations, Surgeries & Accidents

☐ Tonsils: _____ ☐ Cysts/Tumors: _____ ☐ Appendix: _____
☐ Gallbladder: _____ ☐ Uterus/Ovaries: _____ ☐ Other: _____

What other hospitalizations, surgeries or accidents have you had? (include date)

Symptoms

Please place a **check mark** next to all symptoms are you **currently** experiencing or have experienced in the **past year**. If there are multiple symptoms listed on one line, please **circle** all that apply.

General

Height: Current Weight: Weight 1 Year Ago: Max Weight: When:

- ☐ Poor Appetite
- ☐ Hearing Loss
- ☐ Easy to Bleed or Bruise
- ☐ Strong Thirst
- ☐ Always Cold
- ☐ Always Hot
- ☐ Cold hands and feet
- ☐ Puffiness or Swelling
- ☐ Night Sweats
- ☐ Sweating without exertion
- ☐ Changes in Appetite
- ☐ Weakness
- ☐ Fevers
- ☐ Sweat Easily
- ☐ Poor Sleep
- ☐ Poor Balance
- ☐ Cravings
- ☐ Sudden Energy Drops
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other

Skin/Hair

- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Pimples
- ☐ Dry Skin
- ☐ Recent Moles
- ☐ Dandruff
- ☐ Recent Hair Loss

Head/Face

- ☐ Migraine
- ☐ Frequent headaches
- ☐ Dizziness
- ☐ Poor memory
- ☐ Head Feels "Cloudy" or "Heavy"
- ☐ Facial Paralysis
- ☐ Facial Pain
- ☐ Lip/Tongue Sores
- ☐ Concussions
- ☐ TMJ Pain
- ☐ Toothache

Eyes

- ☐ Blurred Vision
- ☐ Floaters
- ☐ Cataracts
- ☐ Watery Eyes
- ☐ Dry Eyes
- ☐ Itchy Eyes
- ☐ Eye Pain/Strain
- ☐ Night Blindness

Ears

- ☐ Ear Ringing
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Congestion
- ☐ Dizziness

Nose/Throat

- ☐ Allergies
- ☐ Sinus Infections
- ☐ Sinus Headaches
- ☐ Trouble Swallowing
- ☐ Sensation of Lump in Throat
- ☐ Recurrent Sore Throat

Respiratory

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Phlegm
- ☐ Coughing up Blood

Cardiovascular

- ☐ Chest pain
- ☐ Tightness in chest
- ☐ Heart palpitations
- ☐ Irregular heart rhythm
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Edema/swelling
- ☐ Previous heart attack

Appetite/Thirst

- ☐ Increased /decreased appetite
- ☐ Crave sweets
- ☐ Crave sour taste
- ☐ Crave salty taste
- ☐ Always thirsty
- ☐ No thirst

Digestion

- ☐ Heartburn
- ☐ Chronic gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Cramping
- ☐ Gallstones
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Irritable Bowel
- ☐ Colitis
- ☐ Food allergies

Genito-urinary

- ☐ Pain or burning on urination
- ☐ Frequent urination
- ☐ History of frequent infection
- ☐ Waking at night to urinate
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Kidney stones

Sleep

- ☐ Difficulty falling asleep
- ☐ Waking frequently
- ☐ Nightmares
- ☐ Snoring
- ☐ Muscle cramps

Energy Level

☐ Fatigue ☐ Heavy limbs ☐ Restlessness
☐ Difficulty waking ☐ Excessive energy

Mental Health

☐ Anxiety ☐ Depression ☐ Phobias ☐ Anger / irritability
☐ Panic attacks ☐ Bipolar disorder ☐ Sadness / grief ☐ Fear / worry

Muscles and Joints

☐ Arthritis in: ☐ Tendonitis ☐ Sciatica ☐ Low back pain
☐ Bursitis in: ☐ Stiff or tight muscles ☐ Neck pain

Women's Health

☐ Irregular periods ☐ Cramping ☐ Uterine fibroids ☐ Miscarriage
☐ Heavy or light periods ☐ Endometriosis ☐ STD ☐ # of pregnancies:
☐ PMS ☐ Ovarian Cysts ☐ Irregular ovulation ☐ # of children:

Men's Health

☐ Difficult/unusual urination ☐ STD ☐ Discomfort or pain in genital area ☐ Diminished or excessive sexual drive
☐ Erectile dysfunction ☐ Prostate Problems

Miscellaneous

☐ Traveled outside the USA within the last two years to:

Have you ever been diagnosed or exposed to the following:

☐ HIV Diagnosis & Treatment Dates:_____
☐ Hepatitis Diagnosis & Treatment Dates:_____
☐ Tuberculosis Diagnosis & Treatment Dates:_____

Have you ever been exposed in significant or long-term doses to:

☐ Chemicals ☐ Toxins ☐ Radiation ☐ Other: _____

Habits/Lifestyle

How do you rate your stress level on a scale of 1-10? 0 = lowest, 10 = highest: _____

Do you consume:

☐ Cigarettes or tobacco _____ packs a day
☐ Coffee/tea/soda _____ cups a day
☐ Sugar _____ times a day
☐ Processed/Fast foods _____ times a day
☐ Alcohol _____ drinks per week
☐ Marijuana/other drugs _____ times per week

How much water do you drink per day?

Do you exercise regularly? ☐ Y ☐ N What and how often?

Typical Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you strongly desire any particular foods?

Do you strongly dislike any particular foods?

Are there any foods that aggravate any of your symptoms or make you feel bad?

Allergies

Are you hypersensitive or allergic to any of the following? Please list.

Medications:

Foods:

Plants:

Animals:

Pollens:

Environmental:

Chemicals:

Latex:

MSG:

Other:

Family History

☐ Please check here if you are adopted or otherwise unaware of your family's medical history

Please Check All that Apply	Self	Mother	Father	Grandparent	Siblings	Children	Spouse
Cancer							
Heart Disease							
Digestive Problems							
Respiratory Problems							
Urinary Tract Problems							
Diabetes							
Hypoglycemia							
Thyroid Disease							
Gall Bladder Problems							
High/Low Blood Pressure							
Anemia							
Migraines							
Stroke							
Epilepsy							
Tuberculosis							
Allergies							
Asthma							
Osteo/Rheumatoid Arthritis							
Blood Disorder							
Kidney Disease							
Lupus							
Birth Defects							
Mental Health Concerns							
Substance Dependency							
Age at death, if applicable	NA						
Cause of Death	NA						
Other							

_____ _____

Patient or Guardian Signature Date