

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
- other _____

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
- Depression Panic attacks Nausea Fecal incontinence Bleeding
- Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
- Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____

- Weight lift - #days/wk _____
- Stretch - #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals - which ones _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

I Would Like To:

- ENERGY - VITALITY
- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive
- BODY COMPOSITION
- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible
- STRESS, MENTAL, EMOTIONAL
- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated
- LIFE ENRICHMENT
- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

KINGSTON HEALTH ASSOCIATES
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____

PATIENT SOCIAL SECURITY # _____ - _____ - _____

Please list any person that we may communicate with in relation to your medical condition or treatment and also that we could discuss your account with. For example, spouse, children, mother, father, sister, brother, etc.

Please understand that if you do not list anyone below then we will not be able to communicate with anyone but yourself regarding your protected health information.

I understand that this authorization will expire on an indefinite period.
I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying KINGSTON HEALTH ASSOCIATES in writing.
I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable)
I may inspect or copy any information used or disclosed under this agreement.
I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

Patient signature or Patient Representative Signature _____
Date

Printed Name of Patient's Representative _____
Relationship to Patient

KINGSTON HEALTH ASSOCIATES

INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we furnish information to you regarding your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. However, at some time in the future you may not have the ability to make such decisions. By giving advance directions, you can express your wishes to your family and your healthcare provider about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have “Durable Power Of Attorney For Healthcare” for you. This person is allowed to make healthcare decisions for you including life support decisions, but only after your healthcare provider certifies that you are no longer able to make your own decisions.

You can also leave advance directives about life support by executing a “Living Will”. A Living Will tells your healthcare provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and no longer able to make decisions for yourself.

If you already have a Living Will or durable Power of Attorney for Healthcare, please tell your healthcare provider. We need to put a copy of that documentation in your medical record in order to honor your wishes. If you want more information on how to make a Living Will, Please feel free to ask your healthcare provider, hospital worker, or your attorney.

It is our policy to honor our patient’s healthcare decisions to the fullest extent required or allowed by law. You are not required to give advance healthcare decisions to receive healthcare at this facility.

Please answer the following questions:

Do you have a Living Will?	Yes _____	No _____
If yes, have you given us a copy?	Yes _____	No _____
If no, will you provide us a copy?	Yes _____	No _____

Do you have a Durable Power of Attorney?	Yes _____	No _____
If yes, have you given us a copy?	Yes _____	No _____
If no, will you provide us a copy?	Yes _____	No _____

Patient signature

Date

KINGSTON HEALTH ASSOCIATES

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

Patient's SS# _____ - _____ - _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose you protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and / or disclosed and describes certain rights you have regarding you health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to you health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** you Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative.)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: NITA DOWKER

Practice Address: 900 Waterford Place, ste 100
Kingston, TN 37763

Phone: (865) 717-1121

Fax: (865) 717-1103

E-Mail: nitadowker@yahoo.com

KINGSTON HEALTH ASSOCIATES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ Please Print your Name Here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

Date Employee Signature

KINGSTON HEALTH ASSOCIATES
AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT'S NAME: _____
DATE OF BIRTH: _____ SOCIAL SECURITY # _____ - _____ - _____
MAILING ADDRESS: _____
CITY/ST/ZIP: _____
PHONE: _____ EMAIL: _____

RELEASE OF INFORMATION TO KINGSTON HEALTH ASSOCIATES

I AUTHORIZE THE RELEASE OF INFORMATION FROM:

NAME OF PHYSICIAN, INSTITUTION, ETC. _____

ADDRESS: _____

PLEASE SEND THE REQUESTED INFORMATION TO:

KINGSTON HEALTH ASSOCIATES
900 WATERFORD PLACE, STE 100
KINGSTON, TN 37763
PH (865) 717-1121 FAX (865) 717-1103

RELEASE INFORMATION FROM KINGSTON HEALTH ASSOCIATES

I AUTHORIZE KINGSTON HEALTH ASSOCIATES TO RELEASE COPIES OF MY RECORDS AS LISTED BELOW. THE INFORMATION SHOULD BE SENT TO:

NAME OF PHYSICIAN, INSTITUTION, SELF, ETC _____

ADDRESS: _____

TELEPHONE # _____ FAX # _____

DATES OF TREATMENT REQUESTED:

(THE INFORMATION THAT IS TO BE RELEASED SHOULD BE DETAILED TO SPECIFIC DATES OF SERVICE, TREATMENT, ETC. A MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED SHOULD BE PROVIDED.)

CHECK ALL THAT APPLY:

- DISCHARGE SUMMARY
- HISTORY AND PHYSICAL
- OPERATIVE REPORT
- RADIOLOGY
- ER REPORTS
- PHYSICIAN ORDERS / NOTES
- EKG
- LAB
- OTHER _____

PURPOSE OF RELEASE:

- CONTINUATION OF CARE
- ATTORNEY
- SOCIAL SECURITY
- WORKMAN'S COMPENSATION
- DISABILITY
- INSURANCE
- DEPOSITION
- BILLING
- OTHER _____

KINGSTON HEALTH ASSOCIATES

AUTHORIZATION TO RELEASE HEALTH INFORMATION

EXPIRATION: EXPIRATION DATE FOR EXPRESSED AUTHORIZATION IS _____, IF THE PATIENT DOES NOT EXPRESS A DESIRE FOR A SPECIFIC DATE OR CONDITION TO REVOKE THEIR AUTHORIZATION, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE SIGNED BY THE PATIENT OR LEGAL AUTHORIZED AGENT.

REDISCLASURE: I understand that the information used and/or disclosed according to this authorization may no longer be protected by Federal Privacy Law (also known as HIPPA) and the recipient of you health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

REVOCACTION: I have read, or have had read to me, the above statement, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the KINGSTON HEALTH ASSOCIATES AUTHORIZATION TO RELEASE HEALTH INFORMATION patients or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist. As detailed by federal law, such as:

KINGSTON HEALTH ASSOCIATES has taken in reliance thereon, or the authorization was obtained as a condition of obtaining insurance coverage, whereby another law to contest Claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the patient or patients' legal representative and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

SIGNATURE OF PATIENT OR AUTHORIZED LEGAL REPRESENTATIVE

DATE

(IF A PERSONAL REPRESENTATIVE OF THE INDIVIDUAL SIGNS THE AUTHORIZATION, A DESCRIPTION OF SUCH REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE INDIVIDUAL MUST BE PROVIDED.)

RELATIONSHIP TO PATIENT

WITNESS

DATE