KONA INTEGRATIVE HEALTH & ADVANCED IV CENTER

WWW.KONAHEALTH.COM

Patient Information

Today's Date: ________________

Name: ____ Date of Birth: ______________________

Mailing Address: ________________________________ City, State, Zip: ______________________

Physical Address: ________________________________ City, State, Zip: ______________________

Marital Status: ________________Occupation: ______________ Employer Name: ________________

Home #: ____________________ Cell #: ____________________ May we leave a message? _______

E-mail address: ____

Emergency contact: _____________________ Phone: ______________ Relationship: _____________

How did you hear about us? _____________ Who may we thank for this referral? __________________

What other doctors are part of your health care team? ____

Preferred Pharmacy: ____

Medical History

Please indicate **if you or any of your relatives has had any of the following**: (write self, mother, father, brother, sister, maternal/paternal grandmother, grandfather, aunt, uncle, etc.)

Alcoholism/drug addiction__________________
Allergies, eczema, asthma __________________
Anemia ________________________________
Arthritis ________________________________
Autoimmune disease______________________
Cancer or tumor ________________________
Chronic pain ___________________________
Diabetes ______________________________
Diverticulosis ___________________________
Epilepsy _______________________________
Other _________________________________

Gastrointestinal disorder___________________
Genetic disease _________________________
Heart disease __________________________
High blood pressure______________________
Infectious disease _______________________
Frequent infections ______________________
Kidney or bladder issues __________________
Rheumatic fever _________________________
Thyroid disease _________________________
Ulcer _________________________________

Please list your main concerns and/or health goals in order of importance:

1. ____
2. ____
3. ____
4. ____

Please indicate any past or current serious illnesses, surgeries, or reasons for hospitalization. Include imaging done, such as MRI, CT, EKG, EEG, etc.

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Medications

Are you allergic to any medications? Do you have any environmental allergies or food sensitivities? Please also include your reaction:

____

____

____

Please list all medications you presently take (with dose), including supplements and over the counter medicine:

____

____

____

Screening Tests

Please indicate which of the following screening tests you have received (if known)

Test	Y/N	Write N if normal, A if abnormal	Last Done
Blood sugar			
Hemoglobin A1c			
Complete blood count (CBC)			
Cholesterol			
Vitamin D			
Vitamin B12			
Iron/ferritin			
PSA (men)			
Annual exam/PAP (women)			
Mammogram			
Colonoscopy			
Bone density scan (DEXA)			

Please list any other specialty testing you have had, such as stool testing, food allergy tests, etc:

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____

____

FOR THE FOLLOWING, PLEASE CIRCLE:
Y = yes/condition you have now, **N** = no/never had, **P** = problem in the past, **S =** sometimes a problem now

GENERAL

Weight loss or gain?	Y	N	P	S
Fatigue?	Y	N	P	S
Skin rashes or itching?	Y	N	P	S
Hair changes?	Y	N	P	S
Cold intolerance?	Y	N	P	S
Changes in appetite?	Y	N	P	S
Easy bruising or bleeding?	Y	N	P	S

HEENT

Headaches?	Y	N	P	S
Migraines	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S
Double vision?	Y	N	P	S
Eye pain or redness?	Y	N	P	S
Spots in vision?	Y	N	P	S
Eye pain or redness?	Y	N	P	S
Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Vertigo?	Y	N	P	S
Dizziness?	Y	N	P	S
Frequent ear infections?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nosebleeds?	Y	N	P	S
Dry mouth?	Y	N	P	S
Hoarseness?	Y	N	P	S

CARDIOVASCULAR & RESPIRATORY

Chest pain?	Y	N	P	S
Palpitations?	Y	N	P	S
Known murmurs?	Y	N	P	S
Swelling?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Wake gasping for breath?	Y	N	P	S
Asthma?	Y	N	P	S
Cough?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Nausea or vomiting?	Y	N	P	S
Heartburn?	Y	N	P	S
Bloating?	Y	N	P	S
Abdominal Pain?	Y	N	P	S
Belching or gas?	Y	N	P	S
Change in bowl habits?	Y	N	P	S
Constipation?	Y	N	P	S
Diarrhea?	Y	N	P	S
Black stools?	Y	N	P	S
Undigested food in stool?	Y	N	P	S
Travel outside of the country?	Y	N	P	S
Frequent antibiotic use?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Painful urination?	Y	N	P	S
Nighttime urination?	Y	N	P	S
Blood in urine?	Y	N	P	S
Incontinence?	Y	N	P	S
Frequent UTI's?	Y	N	P	S

MUSCULOSKELETAL

Joint pain?	Y	N	P	S
Joint swelling?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Muscle weakness?	Y	N	P	S

NEUROLOGICAL

Numbness or tingling?	Y	N	P	S
Loss of balance?	Y	N	P	S
Memory loss or confusion?	Y	N	P	S
Tremors?	Y	N	P	S

WOMEN

Question				
Age of first menses?	____________			
Age of last menses?	____________			
Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
Bleeding between cycles?	Y	N	P	S
PMS?	Y	N	P	S
Sexually active?	Y	N	P	S
Method of birth control?	____________			
Any difficulty getting pregnant?	Y	N	P	S
Pain with intercourse?	Y	N	P	S
Vaginal discharge?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Do you do self breast exams?	Y	N	P	S

MEN

Question				
Discharge or sores?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Impotence?	Y	N	P	S
Sexually active?	Y	N	P	S

MIND/STRESS

Question				
Depression?	Y	N	P	S
Anxiety?	Y	N	P	S
Change in sleep patterns?	Y	N	P	S
Suicidal thoughts?	Y	N	P	S

OTHER

Question				
Do you use tobacco?	Y	N	P	S
If in the past, how many years?	____________			
How many packs per day?	____________			
Do you drink alcohol?	Y	N	P	S
Use recreational drugs?	Y	N	P	S

Payment Policies

Early in Dr. Roberts' practice, she realized she would not be able to deliver the highest quality of care that she is committed to delivering if she allowed insurance companies to dictate how she practiced medicine. She has since decided to opt out of the third-party insurance payment model. This allows her to increase the amount of time spent with each patient, an integral component of her integrative and highly individualized medical model. This is part of Dr. Roberts' commitment to providing solutions for all of your health challenges, no matter how chronic or complex they may be.

Payment in full is expected for services rendered on the day of your visit. We accept cash, checks, and major credit cards. Our office staff would be happy to make claim forms available to you, upon request, to submit to your insurance carrier for direct reimbursement, where applicable. Unfortunately we are not able to determine how much your particular insurance provider might reimburse you for services as there are so many different plans and they vary so much. We recommend that you call your specific insurance provider and ask if they have naturopathic (ND) coverage.

By signing below, I acknowledge that I have read and understand the above-stated payment policies.

Signature: ____ Date: ____________________

Release of Information Authorization

I hereby grant consent to Kona Integrative Health and its personnel to disclose my medical information, encompassing, yet not confined to, appointment schedules, medical history, diagnoses, treatment records, and test outcomes, to the subsequent individual(s) and/or entity:

1. **Name: ______________________________**

   Relationship to Patient: ____________________________________

   Contact Information: _______________________________________

2. **Name: ______________________________**

   Relationship to Patient: ____________________________________

   Contact Information: _______________________________________

By signing below, I acknowledge that I voluntarily consent to the disclosure of my medical information as specified above.

Signature: ____Date: _____________________

Consent For Communication & Your Health Information Privacy Rights

We frequently communicate with patients by phone, voicemail, e-mail or text. Kona Integrative Health respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. We will only communicate with you by e-mail or text with your written consent at the email address or phone number you provide to us.

Correspondence should be brief and concise, and completely related to your medical care. Dr. Roberts will not be able to respond to complicated questions that require a lengthy response. If you ask such a question, she may reply that an appointment is necessary to best answer your question(s). Furthermore, non-medical questions or issues such as billing questions may be forwarded to members of our office staff that are better suited to answer them.

Unless otherwise noted in an auto-reply message to you, you can expect a reply to your e-mail or text within 72 hours. If you do not receive a reply within this timeframe, please call the office. If you are not satisfied with the reply, please make an appointment so that we can more thoroughly answer your questions and address your concerns. You should not utilize e-mail or text for urgent messages or any matter that requires immediate attention. Any urgent issues should be conveyed by calling the practice directly or 911.

I do ***not consent*** to any voicemail, e-mail, or texting communication from Kona Integrative Health.

I consent to all communication, including text, email, and voice messages, with Kona Integrative Health.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law, your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent.

This clinic follows strict HIPPA guidelines to protect your health information. Your record will be kept confidential and will not be released to others unless you request otherwise. You may look at your health record or request a copy of it at any time. Your health records will be kept for a minimum of seven years after the date of your last visit.

By signing below, I acknowledge that I have read and understand the above-stated communication and privacy policies.

Signature: ____ Date: ________________

Informed Consent for Treatment

Please read and sign the following in order to completely understand the risks and benefits of naturopathic care:

I hereby authorize Kona Integrative Health to perform the following specific procedures as necessary to facilitate my healthcare:

- Common diagnostic procedures such as labs, physical exams, and imaging
- Medicinal use of nutrition: therapeutic nutrition and nutritional/herbal supplementation
- Injection therapy: intramuscular and intravenous vitamins, minerals, peptides, and other nutrients
- Regenerative therapies: intra-articular (inside the joint) injections with peptides, ozone, exosomes, stem cells, and/or other therapeutics
- Hormone replacement therapy including pellets
- Use of pharmaceutical medications
- Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction and psychological counseling

I recognize the potential risks and benefits of the procedures as described below:

- **General risks:** allergic reactions to prescribed herbs, supplements and medications, side effects of natural medication, inconvenience of lifestyle changes, emotional distress
- **Potential risks of injection therapy:** pain and swelling at injection site, thrombophlebitis, infiltration, embolism, allergic reaction, and anaphylaxis
- **Potential benefits:** restoration of health and body's maximal functional capacity and optimal wellness, relief of pain, assistance in injury and disease recovery, and prevention of disease or its progression

I understand that any questions I have will be answered by my physician to the best of their ability. I also understand that my physician will explain specific procedures and treatments as I receive care, and if I do not understand the explanation I should ask any questions that I have about that procedure or treatment. I realize that I play an integral role in my healing process and in order to produce results I must take responsibility for my health.

I have read and understand this consent form. I understand that the above procedures and treatments are not mandatory. I further understand the potential risks associated with the above procedures and treatments. With this knowledge, I voluntarily consent to the above procedures and treatments, realizing that no guarantees have been given to me by my physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures or treatments at any time.

Signature: ____ Date: ____________________