KONA INTEGRATIVE HEALTH
INTEGRATIVE & INDIVIDUALIZED PRIMARY CARE MEDICINE
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Patient Information

Today's Date: _____
Name_____ Date of Birth _____ Age _____
Street Address _____City, State, Zip _____
Occupation_____ Marital Status _____
Preferred phone _____ May we leave a message? _____
E-mail address_____ Please check if ok to email: ☐
Emergency contact:_____ Phone_____ Relationship_____
How did you hear about us?_____ Referred by _____
What other doctors do you see: _____

Insurance Information

Name of Insured_____ Insurance company _____
Street Address_____ Policy Group #_____
City, State, Zip_____ Membership # _____

Medical History

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

Alcoholism/drug addiction_____ Genetic disease _____
Allergies, eczema, asthma _____ Heart disease _____
Anemia _____High blood pressure _____
Arthritis _____ Infectious disease _____
Autoimmune disease_____Frequent infections _____
Cancer or tumor _____ Kidney or bladder issues _____
Chronic pain _____ Rheumatic fever _____
Diabetes _____Thyroid disease _____
Diverticulosis _____ Ulcer _____
Epilepsy _____ Other _____
Gastrointestinal disorder _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

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

_____
_____
_____
_____

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
PAP test (women)			
Breast exam			
Mammogram			
Bone density scan (DEXA)			
Digital rectal exam (men)			
PSA test (men)			
Cholesterol			
Vitamin D			
Blood glucose			
HgA1c			
CBC (complete blood count)			
Colonoscopy			

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
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
Cough?	Y	N	P	S
Asthma?	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 bowel 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
Blood 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

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WOMEN

Age of first menses?	_____
Age of last menses? (if postmenopausal)	_____
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
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

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

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

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

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

Signature _____ Date _____

Your Health Information Privacy Rights

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.

Out of respect for your privacy and comfort, please know that if I see you in public I won't approach or greet you unless you initiate the conversation. Please do not take offense as I would be happy to speak with you, however I want you to feel confident that everything pertaining to your medical care will always be kept completely confidential.

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

Signature _____ Date _____

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Email Confidentiality & Policies

We occasionally communicate with patients via email between scheduled appointments to answer brief follow-up questions pertaining to treatments recommended. The following pertains to e-mail correspondence:

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.

Phone calls and e-mails regarding an existing condition requiring more than 10 minutes of attention will incur a fee. Phone calls and e-mails regarding a new condition will incur a fee regardless of time. Dr. Roberts or her staff will notify you if your concern will incur a fee so you may decide if you would be better served by scheduling an office visit.

Email is inherently an insecure manner of communication. Email messages typically travel though many other computers and servers before arriving at their destination. At any point along this pathway, these messages can be intercepted and read by a third party. Additionally, if you share your computer with members of your family or friends, or you use a professional e-mail account that could be accessed by your employer or colleagues, then transmitted information might not be confidential. Therefore we cannot guarantee the confidentiality of any messages that are sent or received from our clinic. All e-mail correspondence will be incorporated into your permanent medical record and will be deleted once this has been done.

Unless otherwise noted in an auto-reply message to you, you can expect a reply to your e-mail 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 for urgent messages or any matter that requires immediate attention. Any urgent issues should be conveyed by calling the practice directly or 911.

I have read the e-mail policies as outlined above, and agree to abide by them. Please also see section titled “Payment Policies” for fees that will incur if email correspondences exceed these requirements.

Signature _____ Date _____

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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 supplementation,
- Injection therapy: intramuscular and intravenous vitamins, minerals, and other nutrients,
- Botanical substances may be prescribed as teas, tinctures, capsules, or tablets,
- 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 her 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 _____

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