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Phone: 425-256-2125
Fax: 425-310-8166
info@insidehealthinstitute.org

Patient Initial Intake Form

Name: _____
Last **First** **MI**

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Email address: _____

Phone # **(H)**_____ **(W)** _____ **(Other)** _____

Can we call you at work? ❑ **Yes** ❑ **No**

Date of Birth: _____ **Sex:** ❑ **Male** ❑ **Female** **SS#:** _____

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated** ❑ **Minor**

Occupation: _____ **Employer:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer Phone: _____

How did you hear about our practice? _____

Emergency contact: **Name:** _____**Relation:** _____

Phone #: **(H)** _____ **(W)** _____

Preferred Pharmacy: **Name:**_____ **Phone #:** _____

Insurance Information

Do you have health insurance? ❑ **Yes** ❑ **No** **Name of Carrier:** _____

Policy Holder Name: _____ **D.O.B. :**_____

Relationship to patient (if other than self): _____ **Phone #** _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

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Health History

PRESENTING PROBLEM: _____

_____

_____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Anemia	❑Arthritis	❑ Blood Disease	❑ Cancer
❑ Cataracts	❑ Colds(frequent)	❑ Diabetes	❑ Digestive Problems	❑ Eczema
❑ Epilepsy	❑ Headaches	❑Hepatitis	❑ Herniated Disc	❑ Herpes
❑ Hypertension	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease	❑ Lyme
❑ Miscarriage	❑ Pneumonia	❑ Prostate Problems	❑ Rheumatoid Arthritis	❑Stroke
❑ Tumors/Growth	❑ Tuberculosis	❑ Ulcers	❑ Urinary Tract Infections	❑Venereal Disease

Please list any medications you are currently taking (Be sure to include dosage/frequency)_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any allergies (medication/food/insects,ect): _____

_____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

What is your daily/weekly intake of the following:
Caffeine _____ **cups/day** **Alcohol** _____ **drinks/week** **Cigarettes/Chew**_____**packs/day**

Diet: ❑Junk Food (fast food & snacks) ❑ Processed (frozen or canned meals) ❑ Standard American (meats, potatoes, fats, desserts)
❑ Wholesome ❑ Vegetarian ❑ Raw Food ❑Other_____

Women's Health: Last menstrual cycle:_____

Number of Pregnancies:_____ **Number of Children:** _____ **Number of Miscarriages:** _____

Any sexual difficulties?_____

Men's Health: Last Prostate Exam: _____**Any sexual difficulties?**_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

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Review of Systems

Please mark if you have experienced any of these symptoms within the last month:

Y	N	Neurological
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

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PATIENT CONSENT FORM

Patient's Name _____

Date of Birth _____/_____/_____

A patient coming to Inside Health Institute to see a provider gives his/her/them permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by Inside Health Institute and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

_____ _____

Signature of Patient or Person Authorized to Consent* **Date**

_____

Relationship (if not Patient)

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to an insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by

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that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to reasonable requests on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosure of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies or procedures of our office. We will not retaliate against you for filing a complaint.

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Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer."

For more information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Service Office of Civil Rights
200 Independence Ave. S.W.
Washington D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Inside Health Institute. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Inside Health Institute to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date