



Weight Loss and Natural Hormone Balancing Clinic.com
Kathryn R. Palmer, APRN, FNP-BC
Family Nurse Practitioner
Ph. (801) 272-1246

New Patient Information

Name (First, Middle, Last)			
Address		City	State Zip
Mobile Phone	Home Phone		Work Phone
Which number should we call to contact you? [Please highlight, underline or circle.]			
Date of Birth	Age	Under 18 Years: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> _____		
E-mail Address			<input type="checkbox"/>

AGREEMENT IN CONSIDERATION OF HORMONE BALANCING, WEIGHT LOSS OR OTHER PRIMARY CARE MEDICAL SERVICES--I, the undersigned, agree to pay:

1. Payment in full at time of service
2. \$45 bank fee for any returned check
3. \$50 fee for a missed visit or scheduled phone consult, without giving 24 hours advance notice

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), I acknowledge that I have received written information regarding my personal health information (PHI) in the form of a *Medical and Financial Privacy Notice*.

Patient's Signature

Date

Feel More Like Yourself Again!



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HEALTH QUESTIONNAIRE

NAME: _____ DOB: _____ AGE: _____ Height: _____ Weight: _____

ALLERGIES

☐ None

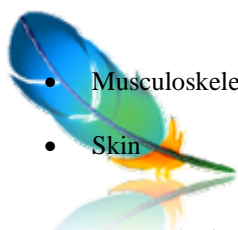
☐ To Medication [Please list any medications you are allergic to, the year of occurrence, and describe your reaction (e.g., rash, itching, swelling, nausea, vomiting, disorientation, etc.): _____]

☐ Environmental [Please list any allergies to pollen, food, animals, etc.): _____]

HOW DID YOU HEAR ABOUT OUR CLINIC? _____ Date or year of your last medical exam: _____

BODY SYSTEMS – Please circle any of the following with which you have had *significant problems* in the past, or have currently:

- Constitutional fatigue, chills, fever, sweats, weight gain, weight loss
- Heart chest pain, heart palpitations or irregular beat, shortness of breath, uncomfortable breathing, ankle swelling, anemia, fainting, heart murmur, rheumatic fever, heart attack, high blood pressure
- Lungs pneumonia, tuberculosis, asthma, chronic cough, bloody sputum, shortness of breath with exertion, wheezing, awakening with shortness of breath
- Eyes uncorrected near- or far-sighted vision, double vision, crossed eyes, redness, pain, swelling, discharge, glaucoma, cataracts
- Ears earaches, deafness, ringing or buzzing, infection, drainage
- Nose nasal obstruction, broken nose, sinus pain, excess drainage, nosebleeds, frequent colds
- Throat hoarseness, changes in voice quality
- Mouth mouth sores, bleeding gums, painful dentures (upper, lower or *both*), untreated cavities
- Gastrointestinal loss of appetite, indigestion, heartburn, nausea or vomiting, abdominal pain, hepatitis, jaundice, blood in stool, change in bowel movements, ulcer, hernia, choking or cough at night
- Genitourinary frequent, painful or bloody urination, flank pain or lower back pain, pus, stones, infection
- Endocrine nervousness, tremors, intolerance to heat or cold; infertility



- Musculoskeletal arthritis, gout, limited motion, pain, weakness, numbness or tingling
- Skin itching, rash, skin disease, sun-damaged skin, sweating, unusual birthmarks; change in size, color or number of moles
- Hematological/Lymphatic bleeding of the skin or mucous membranes, excessive bruising, enlarged or painful glands
- Neurological seizure disorder, fainting, stroke, tremor, coordination problems, nervousness, depression, fear, memory loss, insomnia, mood changes, excessive worry, frequent or severe headache

MEDICAL HISTORY

Serious, chronic illness -- Please list on-going *chronic conditions* for which you have been or are currently being treated (e.g.: *diabetes, gallbladder disease, gout, rheumatoid arthritis, high blood pressure, cerebral hemorrhage, hyper-lipidemia, heart disease, stroke, anemia, high cholesterol, hepatitis, thyroid disease, kidney disease, asthma, pneumonia, cancer, ulcer, epilepsy, psychiatric disorder, sexually transmitted infection, serious injury*)

Please include (1) the diagnosis, (2) the doctor who is currently treating you, and (3) the year the diagnosis was made:

- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____

Surgeries -- List any *major* surgical procedures:

OPERATION	MONTH / YR	HOSPITAL / CITY	SURGEON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations—List any hospitalizations for an illness that did not involve surgery.

ILLNESS	MONTH / YR	HOSPITAL / CITY	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications (excluding any use of hormones, which are listed separately on gynecologic evaluation)

- ☐ Medications: Include the following information for any prescription or over-the-counter medications: (1) name of the drug, (2) dosing & frequency—i.e. how many milligrams & how often? (3) how long have you been taking the medication?

- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____
- (1) _____, (2) _____, (3) _____

- ☐ Supplements: Include any vitamins, minerals, anti-oxidants, herbal preparations, etc.



FAMILY HISTORY

Please (✓) check any of the following *family medical problems*; (a) age at diagnosis and (b) family member's relationship to you (i.e. father, mother, sister, brother, paternal or maternal grandparent, etc.), and if they are still living.

- | | | | | |
|-----------------------------------|--------------------|---------------|------------------------------|-----------------------------|
| ___ <i>diabetes mellitus</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>psychiatric disorders</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>high blood pressure</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>heart disease</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>early age heart attack</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>stroke</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>breast cancer</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ___ <i>cancer, other</i> | (a)____, (b)_____; | still living? | <input type="checkbox"/> yes | <input type="checkbox"/> no |

DIETARY, SOCIAL, AND EXERCISE HISTORY

☐ Dietary

- Please describe your typical food choices for:
 - breakfast: _____
 - lunch: _____
 - dinner: _____
 - in-between meals & bedtime snacks: _____
- Do you have any current dietary restrictions? ☐ no ☐ yes, _____
- Do you experience low blood sugar symptoms when you don't eat, or when you eat simple sugars? (i.e., feeling shaky, light-headed, dizzy, or having increased irritability)? ☐ no, ☐ yes, _____
- Do you experience symptoms of indigestion or constipation? ☐ no, ☐ yes, _____

☐ Social

- Do you have a history of using tobacco products? ☐ yes ☐ no
 - If 'yes,' at what age did you first start to smoke? _____ How many packs/day? _____
 - For how many years? _____ Currently, how many packs/day? _____
 - How many times have you tried to quit? _____
- Do you drink alcoholic beverages? ☐ yes ☐ no
 - If 'yes,' what type of beverages? _____ Total number/volume of drinks per week? _____
- Do you drink soda pop and/or coffee? ☐ yes ☐ no
 - If 'yes,' how much? _____

☐ Exercise

- Do you exercise on a daily basis? ☐ yes ☐ no
 - If 'yes,' do you have increased energy after you exercise? ☐ yes ☐ no, _____
 - What is your current preferred form of exercise? _____
 - How many minutes/day do you typically work-out? _____ How many days of the week? _____
 - How long have you been exercising (i.e., weeks, months, years)? _____

Patient Signature

Date



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GYNECOLOGIC HISTORY

Today's Date: _____

Name: _____ Age: _____ Date of Last Menstrual Period: _____

- ☐ **Hormone use** (synthetic, herbal or bio-identical): Please include all hormone use such as birth control pills, Depo-Provera, Premarin, Prempro, progestins (e.g. MPA), estrogen injections, etc.

Please include the name, dose, and length of time used for each hormone:

- **PAST:** _____

- **CURRENT:** _____

- ☐ **TPAL:** Term births: _____ Pre-term births: _____ Miscarriages: _____ Living children: _____
Ages/gender of children: _____

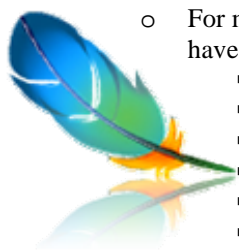
- ☐ Have you ever had problems with any of the following?

- | | | |
|-------------------------------|-----------------------------|--|
| • pre-menstrual syndrome | <input type="checkbox"/> no | <input type="checkbox"/> yes—severity (mild/moderate/severe)_____ |
| • fibrocystic (lumpy) breasts | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • infertility | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • frequent vaginal infections | <input type="checkbox"/> no | <input type="checkbox"/> yes—type (yeast/bacterial) and follow up: _____ |
| • abnormal pap | <input type="checkbox"/> no | <input type="checkbox"/> yes—date(s) and follow up: _____ |
| • miscarriage | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • uterine fibroids | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • ovarian cysts | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • endometriosis | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • endometrial cancer | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • breast cancer | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • ovarian cancer | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |
| • cervical cancer | <input type="checkbox"/> no | <input type="checkbox"/> yes—date and follow up: _____ |

- ☐ Do you have a mother or a sister who has been diagnosed with breast cancer? ☐ no ☐ yes, _____

- ☐ Are you post-menopausal? ☐ no ☐ yes—age at menopause: _____
• If yes, have you had a hysterectomy? ☐ no ☐ yes—date and reason: _____
 ○ If hysterectomy, were ovaries removed? ☐ no ☐ yes

- ☐ Please describe your cycles (use lined spaces provided on page 2)
 ○ For post-menopausal women (including those who have had a hysterectomy), please describe your cycles prior to menopause.



- For menstruating, or pre-menopausal women, please describe your current cycles, as well as noting any changes that have occurred in recent years.
 - *Are (or were) your cycles regular or irregular?*
 - *How many days from the start of one period to the start of the next one?*
 - *Number of days of flow?*
 - *Describe your flow (i.e., light/moderate/heavy).*
 - *Any bleeding between periods?*
 - *Any clots?*

Rate the following symptoms on a scale of 0-10 (0-1 is mild, 5 is moderate, 10 is severe)

<u>Symptom</u>	<u>Severity</u>	<u>How often do they occur?</u>	<u>How long do they last?</u>
Hot flashes	_____	_____	_____
Night sweats	_____	_____	_____
Vaginal dryness	_____		
Foggy Thinking	_____		

<u>Symptom</u>	<u>Severity</u>	<u>Symptom</u>	<u>Severity</u>
Mood Swings	_____	Dry Skin	_____
Irritability	_____	Oily Skin	_____
Anxiety	_____	Acne	_____
Water Retention	_____	Thinning Skin	_____
Breast Tenderness	_____	Hair Loss	_____
Sugar Cravings	_____	Excessive body hair	_____
Heart Palpitations	_____	Facial hair	_____
Backaches w/periods	_____	Puffy Eyes	_____
Depression	_____		
Crying	_____		
Forgetfulness	_____		
Aches/pains, arthritis	_____		

<u>Symptom</u>	<u>Severity</u>	
Fatigue	_____	Time of day you feel most fatigued: _____
Cramps	_____	When do cramps occur, & for how long? _____
Low libido	_____	

Weight gain _____
 - Over how long a time period? _____ Primary location? _____ How many pounds?

<u>Symptom</u>	<u>Severity</u>	<u>Details</u>
Insomnia	_____	_____
Incontinence	_____	_____

<u>*Headache occurrence</u> (please check):	<u>Severity</u>	<u>How long do the headaches last?</u>
_____ occurs prior to menstruation	_____	_____
_____ occurs mid-cycle	_____	_____
_____ occurs during menstruation	_____	_____
_____ occurs with hormone therapy	_____	details: _____
_____ occurs with birth control pills	_____	details: _____
_____ other, _____	_____	details: _____

*For frequent headaches, how many years have they occurred? _____



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Our Front Desk is Online with RelayHealth!

Visit www.relayhealth.com to sign up

We are pleased to offer a convenient way for our patients to communicate with our front desk 24/7. *RelayHealth* is an on-line medical service that can be accessed from anywhere the internet is available, enabling you to send and receive messages when it's most convenient.

The *RelayHealth* service is a safe, secure, and confidential way to communicate about your *non-urgent* healthcare needs. It's as easy to use as Email, but incorporates stronger security measures that ensure your privacy in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

At any time, you can use this service to:

- *Schedule clinic appointments and/or phone consults*
- *Receive appointment reminders*
- *Fill out symptom screening forms in preparation for a phone consult*
- *Access Relay Health's online medical database*
- *Send a quick message to our front desk to ask a question*

Please take a few minutes to sign up, by selecting *Kathryn Palmer* as your provider.

1. Visit www.relayhealth.com
2. Click on the section for *Patients*, then *Register*
3. Select *Kathryn Palmer* as a new provider

If you have any questions, please call the clinic at 801-272-1246, or *RelayHealth Customer Support* at 1-866-RELAYME (1-866-735-2963).

Thank you,

Kathryn R. Palmer, Nurse Practitioner

Feel More Like Yourself Again!



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Family Nurse Practitioner
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Medical & Financial Privacy Policy
in compliance with
Health Insurance Portability and Accountability Act (HIPPA)

Medical Privacy Policy

At Weight Loss and Natural Hormone Balancing Clinic, we share your concerns for privacy and security of personal information. Because we value your privacy, we do not sell or trade any personal information that you have entrusted to us. To help you better understand our privacy policy and practices, we are required by law to prepare this notice for you.

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

1. Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. It may also contain correspondence and other administrative documents. Your health insurance carrier receives and stores this information to provide you with medical benefits. Personal health information (PHI) is any personally identifying information which when linked to health data could be used to identify an individual. This information may be stored or transmitted in any form (for example: paper, electronic, verbal, etc.). All of this information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning and marketing
- Tool by which we can assess and monitor the health care being provided and the outcomes achieved.

2. Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. Federal law gives you the right to:

- Inspect and obtain a copy of your health record (a copying fee of \$25 will be assessed for records > 10 pages)
- Amend your health record
- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Obtain an accounting of disclosures of your health information (other than for purposes of treatment, and health care operations)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Weight Loss and Natural Hormone Balancing Clinic is required to:

- Maintain the privacy of your health information
- Provide notice of our legal duties and privacy practices regarding information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your personal health information without your authorization, except as provided by law. Federal Standards for Privacy of Individually Identifiable Health Information went into effect in April of 2003. Therefore, we reserve the right to change our practices and make the new provisions effective for all PHI we maintain.

We are required to abide by the terms of the written Privacy Notice currently in effect. We reserve the right to change the terms of our Privacy Notice from time to time and to amend or make new notice provisions effective for all PHI we maintain.

3. For More Information or to Report a Problem

If you have any questions or if you would like additional information, you may contact Weight Loss and Natural Hormone Balancing Clinic by calling (801) 272-1246.

If you believe your privacy rights have been violated, you can file a complaint with Weight Loss and Natural Hormone Balancing Clinic or with the Office for Civil Rights (OCR). Complaints must be in writing and can be filed either by mail or electronically. OCR will provide further information on its Web site about how to file a complaint (www.hhs.gov/ocr/hipaa/).

4. Examples of Disclosures for Treatment and Health Care Operations

Pursuant to law and the authorization form which you have signed:

- Treatment, Payment, and Health Care Operations: We may use health information for treatment and health care operations.
- Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
- Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Correctional Institution: If you're an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and for the health and safety of others.
- Law Enforcement: We may disclose certain PHI for law enforcement purposes as required by law.

Financial Privacy Policy

We share your concerns for privacy and security of personal information. Because we value your privacy, we do not sell or trade any personal information that you have entrusted to us. To help you better understand our privacy policy and practices, we have prepared this notice for you.

1. Our Privacy Pledge

Keeping patient information secure, and using it only as you would want us to is a top priority. Weight Loss and Natural Hormone Balancing Clinic restricts access to personal information about you to only those individuals who need to know that information in order to provide products or services to you or your family. We also maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to protect your personal information. Here is our pledge to you:

- We will safeguard any information you share with us according to strict standards of security and confidentiality, including any nonpublic personal information.
- We will limit the collection and use of your information in order to deliver appropriate levels of service.

- We permit only authorized employees trained in proper handling of medical information to have access to your information.
- We will not reveal your information to any other external organization unless we have previously informed you in disclosures or agreements, and have either been authorized by you or are required by law to make such disclosure.
- We will attempt to keep patient files up-to-date and accurate.

2. Information We May Collect

We collect and maintain the following types of nonpublic personal information needed in order to provide you with quality healthcare services:

- Information we receive from you on medical questionnaire forms
- Information we receive from you in letters, telephone calls, visits to our office, etc.
- Information we receive from your employer, such as enrollment or demographic information
- Information we may receive from you when you visit our Internet Web site
- Information we may receive from other third parties
- Information we may receive from credit reporting companies, bureaus, or agencies

3. Information We May Share or Disclose

We may disclose certain information about you without your prior permission with persons or companies as permitted by law for purposes such as:

- To perform services for us
- To state and/or federal agencies and regulatory authorities for required filings and examinations of our records or practices
- To law enforcement agencies or other governmental authorities to report suspected illegal activities
- To your attorney, trustee, or anyone else who represents you or has a legal interest in your medical care
- To persons to whom a court requires us by order or subpoena to provide information
- To persons or organizations conducting actuarial or research studies, subject to appropriate confidentiality agreements
- To our attorneys, accountants, and auditors
- To credit reporting companies, bureaus, or agencies
- To others as permitted or required by law.

4. Our Privacy and Security

We restrict access to nonpublic personal financial information about you to those employees and agents who need to know that information to provide products or services to you and to conduct our internal operations. This information is kept internal to Weight Loss and Natural Hormone Balancing Clinic, except when required or permitted by law. We require certain access codes or personal identification numbers from our patients to enable them to access personal information.

We maintain physical, electronic, and procedural safeguards that comply with applicable regulations to safeguard your personal information. Other than Internet Email, all external electronic transfers of information are encrypted or otherwise protected to ensure that no unauthorized person can gain access to the information. Internet Email will not be used to communicate any personal information to you without your permission.

5. Protecting Your Own Information

Weight Loss and Natural Hormone Balancing Clinic is committed to protecting the privacy of your information. You can help us by following these simple guidelines:

- Protect your insurance account numbers, Personal Identification Number (PIN), password, and Social Security number. Do not give your insurance PIN to anyone. Your insurance PIN can access not only all of the protected health information for you and any covered family members, but also your nonpublic personal financial information.
- Use caution when disclosing numbers or information to others. If someone calls you and claims to be calling on behalf of your insurance carrier and asks for your information, you should be aware. Your personal insurance carrier will normally have access to your information and will not need to ask for it.
- Be careful about information you provide by Email, as this channel of communication is not secure against interception.