CONFIDENTIALITY STATEMENT

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we follow strict security protocols and processes.

We use the highest level of customer and web site security features to guarantee your privacy and security. We never allow 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

You privacy is important to us and we use every care to secure your privacy rights!
HIPAA: Health Insurance Portability and Accountability Act
This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully.

In compliance with the 1996 Congressional act to protect the privacy of patients protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes:

Treatment: Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may included but is not limited to: History and physical, progress notes, laboratory reports, x-ray reports, operative reports, consultation reports, hospital discharge reports, hospital DNR , to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient/client's present and future care.

Operations: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint.

We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request.

_____ _____

Patient Signature Date

HEALTH PROFILE/QUESTIONNAIRE

CONFIDENTIAL MEDICAL HISTORY

PATIENT INFORMATION

Last Name	*First*	*MI*	*Female ( )* *Male ( )*	*Birth Date*	*Age*
Address	*Apt#*	*City*	*State*		*Zip*
Home Phone	*Cell Phone*		*Work Number*		
E-Mail			*Marital Status*		
Height	*Weight*		*Goal Weight?*		
Emergency Contact	*Relationship*			*Phone*	

Medical – Social History

Do you use tobacco? ☐ Yes ☐ No Frequency_____Quantity_____
Do you use alcohol? ☐ Yes ☐ No Frequency_____Quantity_____
Do you use caffeine? ☐ Yes ☐ No Frequency_____Quantity_____
Do you use recreational drugs (e.g. marijuana, cocaine,, etc.) ☐ YES ☐NO ☐ Previously
If yes # of years_____ Year Quit_____

Primary Care Physician: **Address:** **Phone:**

_____

_____

Medical Conditions/Diseases: Please check all that apply to you. ☐ **None**

☐ Heart Disease (Ex: Congestive Heart Failure)
☐ High Cholesterol or Lipids (Ex: Hyperlipidemia)
☐ High Blood Pressure (Ex: Hypertension)
☐ Lung Condition (Ex: Asthma, Emphysema, COPD) (Glaucoma, etc)
☐ Ulcers (Stomach, Esophagus)
☐ Diabetes
☐ Blood Clotting Problems
☐ Arthritis or Joint Problems
☐ Thyroid Disease
☐ Headaches/Migraines
☐ Hormone Related Issues
Other: Please list:_____
☐ Cancer
☐ Depression
☐ Epilepsy
☐ Eye Disease
☐ Kidney Disease

Current Prescription Medications: ☐ **None**

Medication Name	Strength	Date Started	Times Per Day

Allergies to Medications: ☐ **None**

Drug Type of reaction (e.g. hives, wheezing, swelling, upset stomach, etc.)

_____

_____

_____

_____

Over the Counter Medicines (e.g., aspirin, Tylenol, Aleve, Ibuprofen, vitamins, herbals, etc.)

☐ **None**

_____

_____

Have you had any of the following tests performed: Check all that apply and list date.

Mammography	☐ No	☐ Yes	Date:_____
PAP Smear	☐ No	☐ Yes	Date:_____
PSA (males)	☐ No	☐ Yes	Date:_____

Surgical History (e.g., hernia, appendectomy, hysterectomy, etc.) ☐ **None**

_____

_____

_____

Family History

	Living/Age	**Significant health Problems**	**Deceased/Age Cause**
Father			
Mother			
Siblings			
Children			

Check if any health problems exist and enter family member(s).

Health Problem	Family Member(s)	Health Problem(s)	Family Member(s)
☐ High blood pressure		☐ Diabetes	
☐ Heart disease		☐ Gastrointestinal	
☐ Kidney Disease		☐ Bleeding Problems	
☐ Cancer		☐ Other	

Other Concerns/Miscellaneous

_____

_____

_____

_____

PATIENT SIGNATURE_____DATE_____