Health problems you would like to address with Dr. Smith:

____

____

Conditions	Have you ever experienced this?	Has a close family member?	Please explain.
ADD/ADHD	Yes ____	Yes ____	
Alcohol Abuse	Yes ____	Yes ____	
Allergies	Yes ____	Yes ____	
Asthma	Yes ____	Yes ____	
Anxiety	Yes ____	Yes ____	
Cancer	Yes ____	Yes ____	
Cholesterol	Yes ____	Yes ____	
Depression	Yes ____	Yes ____	
Diabetes	Yes ____	Yes ____	
Drug Abuse	Yes ____	Yes ____	
Enviornmental Sensitivites	Yes ____	Yes ____	
Emphysema	Yes ____	Yes ____	
Food Allergies/Sensitivites	Yes ____	Yes ____	
Headaches	Yes ____	Yes ____	
Heart Attack	Yes ____	Yes ____	
High Blood Pressure	Yes ____	Yes ____	
Liver Disease	Yes ____	Yes ____	
Seizures	Yes ____	Yes ____	
Stomach Ulcers/Reflux	Yes ____	Yes ____	
Stroke	Yes ____	Yes ____	
Other	Yes ____	Yes ____	

Do you know if you have ever been exposed to harmful environmental substances?

____

____

____

Please list any supplements, vitamins or herbs you are taking now.

Brand or Other Name	Reason	Year Started	Dosage
Example:StJohn'sWart	*Feeling Down*	*2010*	*3 caps*
____________________	____________	____________	________
____________________	____________	____________	________
____________________	____________	____________	________
____________________	____________	____________	________
____________________	____________	____________	________
____________________	____________	____________	________
____________________	____________	____________	________

Review of Symptoms: Please check no/yes for the following **current** symptoms(within past 3 months)

GENERAL	YES	NO		**GASTROINTESTINAL**	YES	NO
Fever				Diarrhea/Constipation		
Sweats at night				Indigestion/heartburn		
Hot flashes				Nausea		
Temperature intolerance				Blood in stool		
Excessive thirst				**GENITOURINARY**		
Fatigue				Pain or burning on urination		
Sleep difficulties				Frequent urination		
Daytime sleepiness				Waking to urinate more than once a night		
Unplanned weight change				Urinary incontinence		
SKIN				Decreased sexual desire		
Rash				Pain with intercourse		
New or changing moles				Sexually Transmitted Diseases		
EYES				Fertility issues		
Pain				**MEN**		
Redness				Testicle Pain		
Vision, change				Erectile Dysfunction		
EAR,NOSE, THROAT				**WOMEN**		
Hearing loss				Libido problem		
Ringing in ears				PMS		
Dizziness or vertigo				Heavy menstrual bleeding		
Bleeding gums				Painful menstrual periods		
Nosebleeds				Irregular menstrual bleeding		
Teeth/Jaw problems				**MUSCULOSKELETAL**		
BREAST				Generalized or all-over pain		
Breast pain				Joint pain		
Masses and or Lumps				Stiffness		
Nipple discharge				Joint swelling		
Skin changes				Back or neck pain		
CARDIOVASCULAR				**NEUROLOGICAL**		
Chest pain				Headache severe and/or frequent		
Irregular heart beat				Seizures		
Leg swelling or edema				Muscle weakness, TIA or stroke		
PULMONARY				Memory problems		
Asthma				Fainting or loss of consciousness		
Chronic cough				Localized numbness, tingling, neuropathy		
Dizziness				**PSYCHOLOGICAL**		
Wheezing				Anxiety		
Shortness of breath				Depression		
HEMATOPOIETIC				Memory loss		
Anemia				Mood swings		
Blood clots				Nervousness		
Swollen lymph glands				Insomnia		
				Suicidal feelings		

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? ___Yes ___ No

	Date		Date
Pap/pelvic exam(females)		Zoster(shingles) vaccine	
Mammogram(females)		Hepatitis A vaccine	
Colonoscopy		Hepatitis B vaccine	
PSA		MMR vaccine	
Bone Density(DEXA)		Gardesil(HPV) vaccine	
Tetanus vaccine		Other vaccines	
Flu vaccine			

Please outline your use of the following, past or present:

Product:	Current Use?	Quantity	Quantity	Past Use?	Do others have
	Yes/No	Per Day	Per Week	Yes/No	concern about this?
Tobacco					
Alcohol					
Recreationsl Drugs					
Caffeine					

How many hours of sleep do you usually get each night? ______________________

Describe any issues you have with sleep. ______________________________

____

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction

Please list everything you ate in the last 24 hours.

Morning:
Afternoon:
Evening:
Snack:

Do you currently or have you ever had a problem with weight or eating? __ Yes __ No

If yes, please describe: ______________________________

Are you comfortable with your relationship with food? __ Yes __ No

Do you feel knowledgeable about your nutritional needs? __ Yes __ No

Who prepares your meals? ________________

Personal and Professional Development: Are you currently __ employed? __ retired?
___ working at home? __ care-taking? __ disabled? __ unemployed?
indicate your past occupation if applicable: ______________________________
Are you happy with your occupation? __ Yes __ No
Why? ______________________________
Do you anticipate any work changes in the near future? Retirement, etc. ______________

____
What are your hobbies? ______________________________

Relationships:
What are your living arrangments? ______________________________
Number of children and ages: ______________________________
Are you sexually active? ___ Yes ___ No Are you happy with your sex life? ___________

Physical Environment:
Do you have specific health concerns about your current home or environment(Quality of air, water, etc.)? ______________________________
Have you had hazardous environmental or occupational exposures? If yes, please describe.

____

Spirituality:
What things or activities bring you your greatest joy and meaning? What inspires you?

____

____
What things create the greatest challenges for you? ______________________________

____
What makes you feel connected to the larger world? Describe your spiritual or religious practices if any(i.e., meditation, prayer, time in nature, worship attendance, etc.) _______

____
If time and money were not an issue, describe the things you long to do in your life. _____

____

Mind-Body Connection:
Rate the amount of stress in your life: __ None __ A Little Bit __ Moderate __ Quite a Lot __ Extreme
How well do you manage stress? __ Not at All __ A Little Bit __ Moderate __ Quite well __ Excellent
What are the main sources of stress in life?(personal, professional, financial, etc.) __________

____
What are your methods of coping with the stress in your life? ________________________

____

What are your health goals? What are your overall goals for improving your health and your life?

____

____
Is there anything else that would be helpful for us to know about you? _______________

____

JOHNSON CITY OSTEOPATHIC PERSONALIZED MEDICINE
111 W. TENTH AVE.
JOHNSON CITY, TN 37604
423-722-9355
COLEEN M. SMITH, D.O.

Office Policies

1. Office hours are by appointment. Office hours include Mon, Tues, Wed, and Fri. 9:00am-5:00pm. Dr. Smith will be available for emergencies after hours by calling Rebecca at 423-797-0963.

2. A 24-hour notice is required for cancellation; otherwise you will be billed for half of the appointment time.

3. Dr. Smith and JCOM are not responsible for any billing associated with your insurance. **Full payment is expected at the time of service unless other arrangements are made in advance.** JCOM accepts cash, checks, VISA, MasterCard, Discover and American Express. A receipt for your office visit will be provided.

4. Dr. Smith has not contracted with Medicare or Medicaid and **you will NOT be able to submit claims to Medicare or Medicaid for reimbursement.** If you need tests performed you may go to a Medicare approved lab or x-ray department and they will bill you via the typical Medicare system.

5. Any lab services, hospital services, and/or x-ray services will be billed by the facility where they are performed.

6. Dr. Smith requires all patients have a primary care provider. Dr. Smith does not admit patients to the hospital. Should you need hospitalization, you will be referred to either your primary care physician or the hospital emergency room. Referral, however does not assure admittance.

7. If you need a prescription refill please call before you are completely out of your medication. Prescription refills will be called in to the pharmacist during normal office hours.

I have read and understand the above office policies, and I agree to them as a condition for being seen by Dr. Smith. I have received a copy of this form.

______________________________ ____________
Signature Date

____
Print Name

JOHNSON CITY OSTEOPATHIC PERSONALIZED MEDICINE
111 W. TENTH AVENUE
JOHNSON CITY, TN 37604
RELEASE FORM/AGREEMENT
Coleen M. Smith, D.O.

Patient Name: ______________________________ Date: ______
Last First MI

Address: ______________________________
Street Apt.

____
City State Zip Code

Date of Birth: ________ Social Security Number: ____________ Sex: F____ M____

Phone: (___)____________, (___)____________, (___)____________
Home Business Cellular

Email Address: ______________________________

Occupation/Employer: ______________________________

Primary Care Physician: ____________________ Phone: __________

Responsible Party Name, if not Patient: ______________________________

Address, if different from Patient: ______________________________
Street Apt.

______________________________ (___)__________
City State Zip Code Phone

Date of Birth: _______ Social Security Number: ____________ Sex: F____ M____

Phone: (___)____________, (___)____________, (___)____________
Home Business Cellular

Patient and Responsible Party, if any, hereby release Coleen M. Smith, D.O., from all responsibility to issue a report to anyone other than the patient of Dr. Smith's diagnosis of patient's condition, her treatment plan for patient and her prognosis.

Patient acknowledges that patient is seeking help for patient's physical condition, not expert testimony.

Patient and Responsible Party, if any, acknowledge that there will be a reasonable charge for copies of patient records should patient make a written request for the same.

Patient and Responsible Party, if any, acknowledge that Coleen M. Smith, D.O., will not accept an assignment of insurance benefits (including Medicare, Medicaid, TennCare, Workman's Compensation or Accident cases or private insurance) as payment for her services. Patient or Responsible Party must pay for Dr. Smith's services and seek reimbursement from the applicable insurer or benefits provider, if any.

Patient also acknowledges that Coleen M. Smith, D.O., does not treat patients who have received an injury in the course of their employment or as the result of negligence or "accident" while the case is in litigation.

Patient and Responsible Party, if any, agree to the above and to pay, jointly and severally, for all services rendered to Patient by Coleen M. Smith, D.O., including finance charges at 1.5% per month (18% APR) and all collection costs, including attorney fees.

______________________________ ______________
PATIENT or LEGAL REPRESENTATIVE DATE

PATIENT HIPPA ACKNOWLEDGEMENT

I have read Notices of Privacy Practices for Protected Health Information established by Johnson City Osteopathic Medicine before signing this document. This notice has been made available to me and describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills, or in the performance of health care operations of the practice. It describes my rights and the practice's duties with respect to my protected health information.

A copy of the Privacy Notice is available in the waiting room at Johnson City Osteopathic Medicine.

The practice reserves the right to change the privacy practices that are described in the Privacy Notice. I may obtain a revised Privacy Notice by calling the office and contacting the office personnel.

____

Signature Patient/or Legal Representative | Printed Name | Date

To be completed if the staff is unable to obtain a signature.

On ___________ I attempted to obatain a written acknowledgement of receipt of the Privacy notice from the above named person but was unable to because:

( ) Patient declined to sign this consent form.

( ) Patient did not understand this consent form.

( ) Other (specify)____.

____

Office Personnel