New Patient Questionnaire
Dr. Kristin van Konynenburg, M.D.
Whole Family Health Care of Longmont, PLLC

Date: ____ Phone #: ____________________

Name: _______________________________________ Email: ______________________

Address: ____ DOB: _______________

Place of birth: ____

Emergency Contact Person and Phone # and Address: ____________________________

____

Insurance provider: ____

Guarantor: ___________________________________ Guarantor's DOB: _____________

Group #: _____________________________ ID #: ___________________________________

Claim address on card: ____

Employer: ____

Allergies (include all medication, environmental and food allergies/intolerances and what reaction you have to each substance):

____

____

Pharmacy: ____________________________ Phone #: _____________________________

Medications, vitamins, supplements and herbs (include dosage and frequency):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

List any health problems here:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Have you ever had any of the following symptoms chronically or within the past six months (circle any that apply):

fatigue … lightheadedness … fever … chills … night sweats … blurry or double vision … headaches … neck pain … hearing loss … tinnitus … sore throat … runny nose … trouble swallowing … chest pain or pressure … shortness of breath … chronic cough … abdominal pain … acid reflux … constipation … diarrhea … black or bloody stool … joint pain … muscle pain … vertigo … tingling sensations … numbness … weakness … pelvic pain … pain with urination … urinary incontinence … frequent urination … trouble starting or stopping your stream … prostate problems … pain with sex and/or vaginal dryness … changes in hair or nails … depression … anxiety … mood swings

Further details or other symptoms:

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Please include all regular usage, including frequency and amount, both now and past use.
Tobacco: ____
Alcohol: ____
Marijuana: ____
Other drugs: ____

Exercise, including length of time and frequency: ___________________________

Any dietary restrictions? ____
What did you have for breakfast? _____________________________________
Lunch (if last lunch yesterday, give yesterday's lunch)? ______________________
Dinner yesterday? ____

Are you: Married? ______ Partnered? ______ Single? ______
Are you sexually active? ____
Partners men, women, or both? ____

What kind of work do you do? ____
Do you enjoy your work? ____
Do you have a spiritual practice? ____________________ Religion? __________________
Do you feel safe at home? ____
Has anyone ever hurt you at home? ____________________________________
What were the circumstances? ____

Family Medical History:

Mother: ____

Father: ____

Maternal grandfather: ____

Maternal grandmother: ____

Paternal grandfather: ____

Paternal grandmother: ____

Sisters/Brothers: ____

____

Give the date of your last study, if you remember:

Colonoscopy: ________________ Pneumonia shot: ____________________

Mammogram: ________________ Flu shot: ____________________

Pap smear: ________________ Hepatitis B series: ____________________

Stool blood test: ______________ Hepatitis A series: ___________________

Tetanus shot: ________________

Do you feel you have a purpose in life or a spiritual path? If so, what is it?

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What do you do for fun? ____

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____

What are some of your health goals over the next year or two? ____________________

____

____

____

(For women): Last menstrual period: _____________ Postmenopausal? ___________

Number of pregnancies: ___ Deliveries: ___ Living children: ___ Abortions: ___

Miscarriages: ___

Whole Family Health Care of Longmont, PLLC
Patient Agreement

Please initial each line and sign at the end of this form:

___ I authorize medical and health care treatment by Kristin van Konynenburg, M.D.

___ I understand that all refills, referrals and letters will be taken care of at the time of an appointment.

___ If I provide incorrect insurance information and a claim is rejected, I agree to a $30.00 fee for the extra time and expense of re-submitting my claim.

___ I agree to a $20.00 fee for any bounced checks.

___ I agree to a $20.00 fee per month for any unpaid bills that are past due over one month after I received a notice and/or invoice.

___ Cancellations or failure to show for an appointment with less than 24 hours notice will result in a $50.00 fee. Exceptions will be made for inclement weather or other situations that make it impossible to be present.

___ Dr. van Konynenburg notifies her patients about the results of all tests that are ordered, regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. If you have undergone routine medical testing and have not received the results within 14 business days, please call the office to ensure that the results of all completed tests are reported back to you.

___ I acknowledge that I have reviewed a copy of the Notice of Health Information Privacy Practices, and have taken a copy if desired (available on clipboard).

___ I authorize Dr. van Konynenburg to release my medical information to any physician or health care practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

___ Dr. van Konynenburg respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or as specifically authorized by you.

___ I understand that I am responsible for all charges incurred for treatments rendered, even if my insurance company determines that any services are non-covered or excluded.

___ I understand that insurance reimbursement may not be available. My insurance company may not pay for office visits where the focus of the consultation is on wellness or herbal medicine, etc. Also, some of the lab tests that are ordered are kits sent to labs using innovative approaches to diagnostics and may not be reimbursed.

___ I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

___ I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

______________________________________ __________________________

Patient signature Date

(or Guardian's signature, if patient is a minor)