ARRIVAL TIME _____

HealthSmart

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM - PREVENTIVE MEDICINE

YOUR VISIT TODAY

FOR OFFICE USE ONLY

APPOINTMENT TIME	_____AGE	_____HEIGHT
_____am/pm	☐ NUTRITION	
_____am/pm	☐ NURSE	
_____am/pm	☐ FITNESS	
_____am/pm	☐ OTHER _____	

Please tell us about yourself:

Today's Date ☐☐ (Month) / ☐☐ (Day) / 2☐ (Year)

1. ☐ Mr. ☐ Mrs. ☐ Ms. First_____ Middle _____ Last _____
2. Address_____City _____ State _____ Zip _____
3. Phone ( ) _____ Cell ( ) _____ E-mail _____
4. Occupation _____ Employer _____
5. Do you live downtown? ☐ Yes ☐ No
6. Do you work downtown? ☐ Yes ☐ No
7. Reason for coming to UAB HealthSmart today_____

If this is your first visit to UAB HealthSmart, please continue with #8-20.

8. Do you have health insurance? ☐ Yes ☐ No
9. How did you hear about UAB HealthSmart? (Please choose as many as apply.)

   ☐ Passing By ☐ Direct Mail ☐ Friend ☐ E-news ☐ Office Staff ☐ Radio ☐ Television ☐ Newspaper ☐ Other _____
10. What is your usual method of transportation? ☐ Walk ☐ Car ☐ Bus/Public Transportation ☐ Bike
11. Date of Birth ☐☐ (Month) / ☐☐ (Day) / ☐☐☐☐ (Year)
12. What is your gender? ☐ Male ☐ Female
13. What is your race/ethnic group?

    ☐ White ☐ African American (Black) ☐ Hispanic/Latino ☐ Asian ☐ Native Hawaiian or Pacific Islander

    ☐ American Indian/Alaska Native ☐ Other
14. What is the highest level of education you have completed?

    ☐ Less than High School ☐ High School Diploma/GED ☐ Some College ☐ 2-year College Degree (Associate)

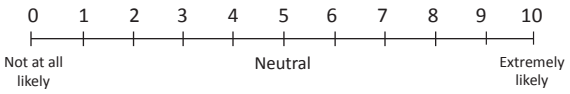
    ☐ 4-year College Degree (BA, BS) ☐ Master's Degree (MA, MPH, MBA) ☐ Professional Degree (MD, JD, OD) ☐ Doctoral Degree (PhD)
15. What is your income? (optional) ☐ 0 - $24,999 ☐ $25,000 - $49,999 ☐ $50,000 - $74,999 ☐ $75,000 - $99,999 ☐ $100,000 or above
16. May we send you announcements about our free programs and events? ☐ Yes ☐ No
17. Preferred way to receive information / reminders from us: ☐ Telephone ☐ Cell ☐ E-mail ☐ Text message on your cell
18. Do you have specific comments or suggestions about your visit to UAB HealthSmart today? Your participation will help us better serve you and your community.

_____

_____

_____

19. On a scale of 0 (not at all likely) to 10 (extremely likely), please tell us how likely you are to recommend UAB HealthSmart to others. _____



20. Which of these health topics would you be interested in learning more about at UAB HealthSmart?

☐ Aging
☐ AIDS/HIV
☐ Allergies
☐ Alzheimer's Disease
☐ Asthma
☐ Autism
☐ Back Pain
☐ Bone Health
☐ Breast Cancer
☐ Cancer (Specify _____)
☐ Cervical Cancer
☐ Child Health
☐ Dental Health
☐ Depression
☐ Diabetes
☐ Digestive Disorders
☐ Fitness/Daily Exercise
☐ Healthy Eating/Nutrition
☐ Heart Health
☐ Heart Disease
☐ Hormone Therapies
☐ Infertility
☐ Knee Pain
☐ Men's Health
☐ Menopause
☐ Mental Health (Specify _____)
☐ Obesity
☐ Prostate Cancer
☐ Scoliosis
☐ Shoulder Pain
☐ Skin Health
☐ Sleep
☐ Smoking/Tobacco
☐ Stress Reduction
☐ Stroke
☐ Substance Abuse
☐ Teen Health
☐ Women's Health
☐ Other_____

Services/Programs completed today:

- ☐ Health Profile
  - ☐ A1C (HEMOGLOBIN)
  - ☐ Blood Pressure
  - ☐ Body Composition
  - ☐ Glucose
  - ☐ Lipid Profile (TOTAL HDL, LDL, TG)
  - ☐ Other _____
- ☐ Health Risk Assessment (computer)
- ☐ Counseling Session
  - ☐ Nurse
  - ☐ Exercise Physiologist
  - ☐ Nutritionist
  - ☐ Other _____
- ☐ General Inquiry/Informational Visit
- ☐ Health Fair Planning
- ☐ Physical Activity Demonstration
  - ☐ WALK Feel Alive
    - ☐ Sign Up
    - ☐ Orientation
    - ☐ City WALK
  - ☐ Xbox Fitness
    - ☐ Sign Up
  - ☐ ZUMBA Fitness Class
    - ☐ Sign Up
  - ☐ Other_____
- ☐ Nutrition Demonstration
  - ☐ Sign Up
- ☐ Lunch & Learn Health Talk
  - ☐ Sign Up
- ☐ Health Education Information
- ☐ Other Services
  Explain _____

Appointment Scheduling:

- ☐ Health Profile
  - ☐ A1C (HEMOGLOBIN)
  - ☐ Blood Pressure
  - ☐ Body Composition
  - ☐ Glucose
  - ☐ Lipid Profile (TOTAL HDL, LDL, TG)
  - ☐ Other _____
- ☐ Counseling Session
  - ☐ Nurse
  - ☐ Exercise Physiologist
  - ☐ Nutritionist
  - ☐ Other _____

Health-care Provider Recommendations

(To be completed by UAB HealthSmart Health-care Provider)

Health-care provider seen today: _____

Return in:
- ☐ 1 month
- ☐ 3 months
- ☐ 6 months
- ☐ 1 year
- ☐ Other _____

- ☐ Health Profile
  - ☐ A1C
  - ☐ Blood Pressure
  - ☐ Body Composition
  - ☐ Glucose
  - ☐ Lipid Profile
  - ☐ Other_____
- ☐ Health Risk Assessment
- ☐ Counseling Session
  - ☐ Nurse
  - ☐ Exercise Physiologist
  - ☐ Nutritionist
  - ☐ Other _____

UAB HealthSmart follow-up services recommended:

Notes:

_____

_____

_____

_____

_____

HealthSmart

YOUR PATH TO BETTER HEALTH

UAB School of Medicine

Acknowledgement of Receipt of Notice

I understand that the UAB School of Medicine may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Health Information Practices that describes how my health information is used and shared. I understand the organization has the right to change this notice at any time. I may obtain a current copy by contacting the School of Medicine. My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

_____ _____

Print (Patient's Name) Patient Medical Record Number

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

Office Use Only

_____ _____

Employee Name Employee Phone Number

Consent to Photograph, Video, or Audio Record ☐ Yes ☐ No

By signing below, I authorize UAB HealthSmart to photograph, video record, or audio record me while participating in the UAB HealthSmart activities for the purposes of publication or marketing by UAB HealthSmart. Uses for recordings may include but are not limited to news releases, website content, printed marketing brochures, training/educational videos, or other authorized forms of organizational communication without compensation of any kind. Each communication may also reveal my name and identity in a descriptive text or commentary associated with any recordings. I relinquish all rights and privileges to any negatives, prints, audio recordings and/or video recordings created by UAB HealthSmart.

Release of Liability

I will be participating in UAB HealthSmart activities as described above for the purpose of improving my knowledge and understanding of certain wellness and chronic disease prevention activities. I hereby release UAB MHRC, UAB HealthSmart, The Board of Trustees of the University of Alabama, a body corporate which operates the University of Alabama at Birmingham, the University of Alabama School of Medicine and the University Hospital and Clinics, UAB Health System, the University of Alabama Health Services Foundation, P.C., and each of its and their divisions, departments, affiliates, related entities, and all present and former trustees, directors, officers, volunteers, employees and personnel (including all physicians and their employers, residents, fellows, interns, medical or dental students, dentists, nurses, laboratory and diagnostic personnel and other health or dental care personnel), agents, and representatives and hold them harmless for any and all liability, claims, damages, actions, and causes of action arising, directly or indirectly, from my participation in UAB HealthSmart activities, the use of any of their services, facilities, or equipment.

Signatures

By signing below, I agree to participate in the UAB HealthSmart activities described above and I release liability associated with my participation in the UAB HealthSmart activities. Unless I checked the “No” box above, I also authorize UAB HealthSmart to photograph me participating in activities.

_____

Signature of Client Date

_____

Signature of UAB HealthSmart Representative Date