

NATURAL HEALTH CLINIC

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Welcome!

Whom may we thank for referring you? _____

Naturopathic physicians are primary health care providers emphasizing optimal health, as well as the natural treatment and prevention of disease.

The goal of your naturopathic physician is to help you enhance the quality of your health and life by working with various treatment modalities such as lifestyle counseling, clinical nutrition, botanical medicine, and homeopathy. Your physician will develop a therapeutic plan that is best suited to you and is most appropriate to your situation. Physicians may perform physical exams and order lab or other studies to gather the information needed to make diagnostic and treatment decisions. Your physician will make referrals to specialists if she believes it is in the best interest of your health.

Initial Free Consultations: (15 minutes) Offered as an introduction to your doctor, and Naturopathy with focus on your particular health problem. This time is not intended for treatment. **If a free consultation is longer than 15 minutes, or culminates in treatment, you will be charged for an office visit.**

Office visits: Charge is based on the complexity of your appointment, and according to allowable standard insurance rates.

Acute care: One of the best benefits of a group practice is that if you have an urgent need, or sudden onsets of symptoms: ear infection, mastitis, or urinary tract infection, for example, you may call for a 5 minute visit with one of our doctors, and we will get you in as soon as possible; usually the same day you call, however it may be with a different doctor than who you've established care with.

Lab and pharmacy: Charges will vary depending on item(s) provided.

Telephone/Email Care: No charge for first 5 minutes. Phone calls that extend beyond 5 minutes will be charged based on office call rates, and cannot be billed to insurance.

Payment is expected immediately following your visit unless other arrangements have been made with the office manager. If you need to cancel or reschedule your appointment, please give us 24 hours notice. This allows other patients the opportunity to fill your time slot. There will be a 35.00 fee charged for cancellations made with less than 24 hour notice.

Insurance: Please provide office personnel with any insurance information prior to your visit. While many companies do cover naturopathy in whole or part, it is better for all parties for patients to understand coverage in advance. Depending on your coverage, we may ask that you pay for services at the time of the visit and be reimbursed directly by your insurance.

Please feel free to ask questions and offer comments about our services! It is our mission to provide quality health care in a comfortable, supportive environment. Thank you.

I have read this handout explaining fees and services.

Patient Printed Name

Patient signature

Date

NATURAL HEALTH CLINIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Laura Shelton, N.D., Emily Sharpe, N.D., or Kelsi Ervin, N.D..

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. This notice is posted for your review at all times in the Clinic waiting room. You may request a copy for your records if you wish.

By my signature below I acknowledge the availability of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship to patient

This form will be retained in your medical record.

NATURAL HEALTH CLINIC

ADULT HEALTH HISTORY

To help us meet all your healthcare needs, please fill out this form completely. Please use ink. This is a confidential record of your health history.

Today's date _____

Name _____
(Last, First MI)

Date of birth _____ Age _____

Relationship status: Single, Married/Partnered, Separated/Divorced, Widowed/Widower

Spouse/Partner name _____

Do you have children? _____ Age(s) _____

What are your goals for today's visit? Please be specific _____

Are you interested in preventative healthcare? _____

Are there any specific conditions that you are concerned about? _____

When was your last physical exam? _____

Name of Doctor _____

When was your last dental exam? _____

Name of Doctor _____

Please list all allergies (food, drugs, environment) _____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and dates these occurred _____

Please describe all serious accidents, severe injuries, head injuries, broken bones and dates _____

Please list all prescription and over the counter medications you are currently taking _____

Please list all nutritional and herbal supplements you are currently taking _____

Name _____

Usual weight: _____ Happy with weight? _____

How much sleep do you get? _____ From _____ p.m. to _____ a.m.

How well do you sleep? _____

What is your daily exercise level? - Light - - Medium - - Heavy -

Do you do any exercise for the sake of your health? _____ What? _____

How long at a time? _____

How often? _____ Do you enjoy it? _____

Over the past few years how would you describe your stress level?

- none - - mild - - moderate - - severe -

In regard to the past several months can you say that you:

Enjoy your job/what you do during the day? _____

Enjoy your relationships with people in your life? _____

Are you feeling confident about your ability to cope? _____

Diet:

Are you vegetarian – vegan –avoiding allergens ? _____

What did you eat yesterday?

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Is this typical? _____ If not, what is? _____

Lifestyle:

Smoking (type & amount per day) _____ If former smoker, date quit _____

Alcohol (type & amount per week) _____

Caffeine (type & amount per week) _____

Recreational drugs (type & amount per week) _____

Do you always wear a seat belt while in a vehicle? _____

Do you always wear a helmet on a bike or motorcycle? _____

Do you practice safer sex? _____

Have you ever felt threatened by an intimate partner or ex-partner? _____

Do you know of any exposure, past or present, to any of the following:

- mercury - lead - arsenic - zinc - herbicides - pesticides - urea formaldehyde (e.g. from foam insulation or particle board) - other toxic chemicals? _____

Name _____

Review of Systems:

Do you have now (please put "C" for current), or have you had within the past year (please put "P" for past year):

- | | | |
|--|--|--|
| <input type="checkbox"/> Weakness or paralysis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Breast lump/discharge |
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Recent weight changes |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Increase in thirst |
| <input type="checkbox"/> Muscle cramps/spasms | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Vomit/cough up blood |
| <input type="checkbox"/> Tire easily or weakness | <input type="checkbox"/> Discharge from ears | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Dark urine |
| <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Decrease in hearing | <input type="checkbox"/> Frequent urination/night |
| <input type="checkbox"/> Skin trouble or changes | <input type="checkbox"/> Purple/white fingers/lips | <input type="checkbox"/> Frequent urination/day |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Persistent hoarseness | <input type="checkbox"/> Difficulty starting urine |
| <input type="checkbox"/> Yellow skin tone | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Chronic/frequent cough | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Heart palpitations/fluttering | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eye pain or problems | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Double/blurred vision | <input type="checkbox"/> Sore tongue or gums | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Infected eyes | <input type="checkbox"/> Enlarged veins | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> Sensitivity to heat/cold | <input type="checkbox"/> Persistent fever |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Night sweats/hot flashes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Abdominal cramping | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Frequent belching |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Lack of sex drive | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Black tarry stools | <input type="checkbox"/> Change in nails or hair | <input type="checkbox"/> Bloody sputum |

Women only:

- | | |
|--|---|
| <input type="checkbox"/> Age period began | <input type="checkbox"/> Date of last period |
| <input type="checkbox"/> How many days between periods? | <input type="checkbox"/> Date of last pelvic |
| <input type="checkbox"/> Is the flow heavy? | <input type="checkbox"/> Date of last mammogram |
| <input type="checkbox"/> Do you bleed or spot between flows? | <input type="checkbox"/> Vaginal itching? |
| <input type="checkbox"/> Do you have pain or cramps? PMS? | |

Men only:

- Discharge from penis
- Pain/lump in testicles
- Impotence

Name _____

Past Medical History:

Please check spaces for conditions that you have had; leave blank if uncertain

<input type="checkbox"/> Measles	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Hives or Eczema
<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> AIDS or HIV+
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infectious Mono
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Polio	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hernia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Ear infection	<input type="checkbox"/> Sinus infection	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Back trouble	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bladder Infections
<input type="checkbox"/> High or low blood pressure		<input type="checkbox"/> Date of last chest x-ray
<input type="checkbox"/> Bleeding tendency		<input type="checkbox"/> Blood or Plasma transfusions
<input type="checkbox"/> Any other disease (please list) _____		

Family Medical History:

Please mark if you have any blood relative that has or has had any of the following conditions.

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Drug/alcohol problem	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Allergies
<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Obesity
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Dementia / Alzheimer's

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

X _____
Patient Signature Date