

**Personal Information**

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Mark the box next to the contact number above that is the best way to reach you, and is okay to leave a message.

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Email Address \_\_\_\_\_

Married/Partnered  Single

**Emergency Contact**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Getting To Know You**

Is another family member/relative a patient here?

Yes  No

Name \_\_\_\_\_

Referred by:

Internet Search/Our Website  Yellow Pages  Sign

Insurance Provider \_\_\_\_\_

Family Member \_\_\_\_\_

Friend \_\_\_\_\_

Other (Explain) \_\_\_\_\_

**Insurance**

**Primary Carrier** \_\_\_\_\_

Insured's Name \_\_\_\_\_

Employer \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

List the name of your insurance's preferred Lab(s):

\_\_\_\_\_

**Secondary Carrier** \_\_\_\_\_

Insured's Name \_\_\_\_\_

Employer \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

List the name of your insurance's preferred Lab(s)

\_\_\_\_\_

**Account Information**

Name of Person Responsible for Account:

\_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_

\_\_\_\_\_

**Closest Relative Not Living With You**

Name \_\_\_\_\_

Relation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Additional Emergency Contact (if first emergency contact is unavailable)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Financial Policy

**Payment:** As a patient of this office you are directly responsible for payment of all charges incurred while under treatment unless you are eligible for insurance reimbursement with an insurance carrier the doctors have contracted with. Payments are due when services are rendered, supplies are received, or laboratory tests are ordered. If the doctor is contracted with your insurance carrier, all deductibles, co-pays and balances that are the patient's responsibility are due at the time of service. Accepted methods of payments are: personal checks, debit and credit Visa and Master cards, and cash.

**Insurance:** If the doctor is contracted with your insurance carrier we will bill your insurance directly. We will make every effort to determine benefits and eligibility prior to treatment. What we are told by your insurance carrier will govern how we determine your liability. We are not responsible for payment discrepancies that might occur once the reimbursement check is received. It is the patient's responsibility to keep track of their deductible, maximum benefit, or other liabilities specific to their plan's coverage. If you are not covered by one of our contracted carriers and think that your insurance will cover naturopathic care, at your request we will provide you with an insurance billing form that you can submit to receive payment from your insurance company. (Weight Loss Programs are not covered by insurance.)

**Senior Discount:** A 10% discount on service (out-source lab, medications received from our dispensary and weight loss programs are not included) will be given to our patients who are age 65 or over. Due to State and Federal regulations, we cannot process medical coupons and Medicare/Medicaid claims.

**Cancellations:** Please give us at least 24 hours advance notice of your inability to keep an appointment. If less than 24 hours notice is received the amount of the scheduled visit will be charged (except in emergencies). Please initial that you understand this:

**Late Fee:** Accounts over ninety (90) days outstanding are overdue and may be acted on for collection. Collection costs are added to your account. A late fee of \$1.50 or 1.0% of the balance per month, whichever is greater, is charged on overdue accounts. There is a \$10.00 charge for returned checks and payment is due in the amount of the check plus the returned check fee within ten (10) working days.

## Authorization for Treatment

I, the undersigned, hereby acknowledge that the care being provided at the Holistic Health Clinic is designed to improve my health or condition. I authorize the doctor to perform diagnostic tests deemed necessary for my care, to perform any and all forms of treatment, to include medication, and therapy that are indicated and that I am in agreement with and are in accordance with the Standards of Naturopathic Care. If procedures are performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. I understand that every effort will be made by the office to fully disclose information about the procedures used. If I have questions about these procedures I will ask them until they are answered to my full satisfaction. I further acknowledge that there is no guarantee or warranty, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.

If while under the doctor's care I experience a medical emergency, I am to dial 911. If I have a medical concern I am to phone the office to report. If my concern occurs during after hours I will phone the office where instructions on how to contact the doctor can be obtained on the after hours message prompts.

I understand and agree to the above *Financial Policy* and *Authorization for Treatment*. I will abide by its terms.

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Signature of Patient or Responsible Party

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Date

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Patient (print)

---

Responsible Party/relationship to patient (print)

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Witness

---

Date

Date: \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Blood Type \_\_\_\_\_ Birth Sex \_\_\_\_\_ Gender Identity \_\_\_\_\_ Pronoun of Choice \_\_\_\_\_

# of Children \_\_\_\_\_ Names & Ages \_\_\_\_\_

**List Your Current Health Problems**

*Prioritize by listing the problems in order of importance.*

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Complete the following section for your top 3 problems (Check the bold descriptors that apply):

**Problem #1:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

**Describe:** \_\_\_\_\_

**Cause:** \_\_\_\_\_  **Constant?** or  **Intermittent?**

**Worsening** or  **Improving?** Why? \_\_\_\_\_

**Rx / Surgery / Treatments tried & the results:** \_\_\_\_\_

**Associated personal and/or family history:** \_\_\_\_\_

**How does problem #1 affect your body / your life?:** \_\_\_\_\_

*Office Use Only* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Problem #2:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

**Describe:** \_\_\_\_\_

**Cause:** \_\_\_\_\_  **Constant?** or  **Intermittent?**

**Worsening** or  **Improving?** Why? \_\_\_\_\_

**Rx / Surgery / Treatments tried & the results:** \_\_\_\_\_

**Associated personal and/or family history:** \_\_\_\_\_

**How does problem #2 affect your body / your life?:** \_\_\_\_\_

*Office Use Only* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Problem #3:** \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Describe: \_\_\_\_\_

Cause: \_\_\_\_\_  Constant? or  Intermittent?

Worsening or  Improving? Why? \_\_\_\_\_

Rx / Surgery / Treatments tried & the results: \_\_\_\_\_

Associated personal and/or family history: \_\_\_\_\_

How does problem #3 affect your body / your life?: \_\_\_\_\_

*Office Use Only* \_\_\_\_\_

List any areas on your body where you feel any of the following sensations (leave blank if not relevant):

Numbness: \_\_\_\_\_

Deep Aching: \_\_\_\_\_

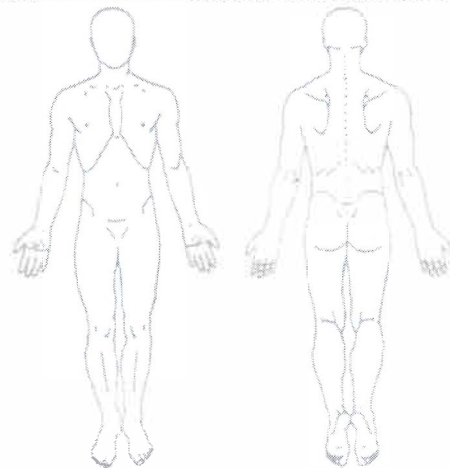
Burning: \_\_\_\_\_

Stabbing: \_\_\_\_\_

Pins & Needles: \_\_\_\_\_

Throbbing: \_\_\_\_\_

Itching: \_\_\_\_\_



**General Information**

Have you seen a naturopathic doctor before?  No  Yes

Are you currently seeing one?  No  Yes Doctor's name: \_\_\_\_\_

Do you have a medical doctor?  No  Yes Doctor's name: \_\_\_\_\_

Have you seen a chiropractic doctor before?  No  Yes

Are you currently seeing one?  No  Yes Doctor's name: \_\_\_\_\_

Do you see any other healthcare professional (i.e. acupuncturist, massage therapist, counselor)?  No  Yes

Explain: \_\_\_\_\_

What are the most significant measures that you have taken to improve your state of health? \_\_\_\_\_

Tobacco Use:  No  Yes Smoke/Chew: \_\_\_\_\_ years – Amount Per Day: \_\_\_\_\_ Year Stopped: \_\_\_\_\_

Alcohol Use:  No  Yes Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Recreational Drug Use:  No  Yes Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Holistic Health Clinic** • 1530 S Union Ave, Suite 4, Tacoma, WA 98405 • 253-752-2558 Review Date/Sig: \_\_\_\_\_

**Your Medical History**

List the prescription and non-prescription medications, vitamins, minerals, & herbs that you are currently taking:

\_\_\_\_\_

List any medications that have been prescribed, but you are not taking: \_\_\_\_\_

List major illnesses, hospitalizations surgeries or serious injuries (include date & brief description): \_\_\_\_\_

Allergies to drugs, food, or other substances?  No  Yes Describe: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_ Max Weight \_\_\_\_\_ When \_\_\_\_\_

Minimum Adult Weight \_\_\_\_\_ When \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart Rate \_\_\_\_\_

**Personal | Family History** (  Unknown )

Please check and name who was affected (Self, Mother, Father, Grandparents, Sisters, Brothers, Children)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV _____      | <input type="checkbox"/> Eczema _____              | <input type="checkbox"/> Psoriasis _____        |
| <input type="checkbox"/> Alcoholism _____    | <input type="checkbox"/> Gout _____                | <input type="checkbox"/> Senility _____         |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Heart disease _____       | <input type="checkbox"/> Sex abuse _____        |
| <input type="checkbox"/> Anemia _____        | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Seizures _____         |
| <input type="checkbox"/> Arthritis _____     | _____  | <input type="checkbox"/> Stroke _____           |
| <input type="checkbox"/> Asthma _____        | <input type="checkbox"/> Hypoglycemia _____        | <input type="checkbox"/> Suicide _____          |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Kidney disorder _____     | <input type="checkbox"/> TB _____               |
| <input type="checkbox"/> Depression _____    | <input type="checkbox"/> Mental illness _____      | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> Migraines _____           | <input type="checkbox"/> Ulcer _____            |
| <input type="checkbox"/> Drug Problems _____ | <input type="checkbox"/> Obesity _____             | <input type="checkbox"/> Other _____            |

**Review of Systems**

Please check all the problems you have currently (in the past week):

<b>Constitutional</b> Good general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Night sweats, fevers <input type="checkbox"/> Fatigue/weakness <input type="checkbox"/>	<b>Ears / Nose / Mouth / Throat</b> Hearing loss or ringing <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat/voice change <input type="checkbox"/>	<b>Eyes</b> Wear glasses/contacts <input type="checkbox"/> Blurred/double vision <input type="checkbox"/> Eye disease or injury <input type="checkbox"/> Eye pain/dryness <input type="checkbox"/>
<b>Cardiovascular</b> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart trouble <input type="checkbox"/> Swelling hands/feet <input type="checkbox"/> Lightheaded <input type="checkbox"/>	<b>Respiratory</b> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing/Asthma <input type="checkbox"/> Coughing up blood <input type="checkbox"/>	<b>Gastrointestinal</b> Nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Indigestion/heartburn/reflux <input type="checkbox"/> Constipation/diarrhea <input type="checkbox"/>
<b>Musculoskeletal</b> Muscle pain or cramps <input type="checkbox"/> Stiffness/swelling joints <input type="checkbox"/> Joint pain <input type="checkbox"/> Trouble walking <input type="checkbox"/>	<b>Neurological</b> Frequent headaches <input type="checkbox"/> Paralysis or tremors <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Numbness/tingling <input type="checkbox"/>	<b>Hematologic / Lymphatic</b> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Slow to heal <input type="checkbox"/> Enlarged glands <input type="checkbox"/>
<b>Endocrine</b> Excessive thirst/urination <input type="checkbox"/> Hair loss <input type="checkbox"/> Cold hands and feet <input type="checkbox"/> Hormone problems <input type="checkbox"/> Light sensitivity <input type="checkbox"/>	<b>Integumentary/Skin</b> Abnormal nails <input type="checkbox"/> Rashes or itching <input type="checkbox"/> Breast irregularity <input type="checkbox"/> Dry/discolored Skin <input type="checkbox"/>	<b>Allergic / Immunologic</b> Food allergies <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hay fever <input type="checkbox"/> Chemical Sensitivity <input type="checkbox"/>
<b>Genitourinary</b> Blood in urine <input type="checkbox"/> Pain/burning on urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Kidney stones <input type="checkbox"/>	<b>Genitourinary - Continued</b> Sexual problems <input type="checkbox"/> Testicle/ovary pain <input type="checkbox"/> Infertility <input type="checkbox"/> Menstrual problems <input type="checkbox"/>	<b>Psychiatric</b> Insomnia <input type="checkbox"/> Confusion/memory loss <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety/panic attacks <input type="checkbox"/>

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Menstrual/Reproductive History (If Relevant)

### Menses

Age period began? \_\_\_\_\_ Date of last period: \_\_\_\_\_

Regular periods?  No  Sometimes  Yes

Periods every days \_\_\_\_\_ (length of time between the start of one period to the start of the next)

Flow:  Heavy  Medium  Light Duration: \_\_\_\_\_ days

Spotting?  No  Yes Midcycle:  No  Yes Instead of period  No  Yes

Bloating?  No  Yes Cyclical premenstrual weight gain:  No  Yes How much? \_\_\_\_\_ lbs.

Cramps?  No  Yes Duration: \_\_\_\_\_ days Intensity:  Mild  Moderate  Severe

PMS?  No  Yes Describe: \_\_\_\_\_

### Pregnancy

Currently pregnant?  No  Yes Planning?  No  Yes When: \_\_\_\_\_

Prior Pregnancies: # \_\_\_\_\_ Births: # \_\_\_\_\_ Miscarriages: # \_\_\_\_\_ Abortions: # \_\_\_\_\_ C-sections: # \_\_\_\_\_

Complications?  No  Yes Describe: \_\_\_\_\_

Type of birth control: \_\_\_\_\_

Ever use birth control pills?  No  Yes How long/When? \_\_\_\_\_

### Hormones

Menopausal?  No  Yes Ovaries present?  No  Yes Uterus present?  No  Yes

Date Uterus or Ovaries were removed: \_\_\_\_\_

Hot flashes?  No  Yes Rx: \_\_\_\_\_ Onset: \_\_\_\_\_

Frequency: \_\_\_\_\_ times per day/week for \_\_\_\_\_ minutes. Intensity:  Mild  Moderate  Severe

Painful intercourse?  No  Yes Vaginal dryness?  No  Yes

### Breast Exam

Breast pain/lumps?  No  Yes Breast discharge?  No  Yes

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Do you do monthly self-breast exam?  No  Yes If not monthly, how often?: \_\_\_\_\_

### Pelvic Exam

Date of last pelvic exam \_\_\_\_\_ Reason: \_\_\_\_\_

Date of last PAP \_\_\_\_\_ Results: \_\_\_\_\_

Previously abnormal PAP?  No  Yes Date \_\_\_\_\_ Results \_\_\_\_\_ Therapy \_\_\_\_\_

Recurring vaginal yeast infections?  No  Yes Onset: \_\_\_\_\_ Frequency: \_\_\_\_\_

### Is there anything else you would like the Doctor to know?

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