Holistic Health Clinic
1530 South Union Avenue, Suite 4 • Tacoma, WA 98405 • 253-752-2558

Personal Information

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Occupation _____

☐ Home Phone _____

☐ Work Phone _____

☐ Cell Phone _____

Mark the box next to 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

Your Partner (first contact in case of emergency)

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 # _____

Secondary Carrier _____

Insured's Name _____

Employer _____

Group # _____

ID # _____

Account Information

Name of Person Responsible for Account:

_____

Social Security # _____

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Business Phone _____

Closest Relative Not Living With You:

Name _____

Relation _____

Address _____

City _____ State _____ Zip _____

Phone _____

Additional Person To Contact In Case Of Emergency (if partner listed above is not available):

Name _____ Relationship _____

Home Phone _____ Cell _____ Work _____

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 tract 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).

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 warrantee, 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.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Patient (print) Responsible Party/relationship to patient (print)

_____ _____

Witness Date

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Name _____ Age ____ Birth Date _____ ❑ F ❑ M Blood Type _____

# 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 effect 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 effect your body / your life?: _____

_____

Office Use Only _____

_____

_____

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 effect your body / your life?: _____

_____

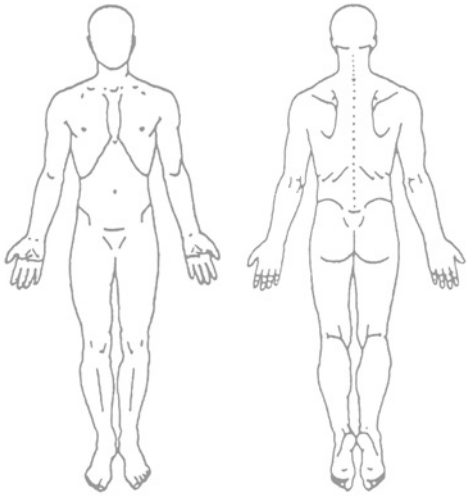
Office Use Only _____

_____

_____

Use diagram to illustrate the areas on your body where you feel any of the following sensations:

Use the following letters to mark the diagram:
A = Numbness
B = Deep Aching
C = Burning
D = Stabbing
E = Pins & Needles
F = Throbbing
G = 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: _____

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)

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

Review of Systems

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

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

Name: _____ Date of Birth: _____

Menstrual/Reproductive History

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?

_____

_____

_____