

## PATIENT INFORMATION SHEET

**PATIENT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Gender: M F Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_

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

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Email \_\_\_\_\_ What is the best way to contact you? \_\_\_\_\_

May we send you our e-newsletters? Y N (We never share info. You may request removal at any time.)

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_

Relationship status: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Partner \_\_\_ Single \_\_\_

Live with: Spouse \_\_\_ Partner \_\_\_ Parents \_\_\_ Children \_\_\_ Friends \_\_\_ Alone \_\_\_ Other \_\_\_

How did you hear about our clinic? \_\_\_\_\_

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**SPOUSE/PARTNER OR GUARDIAN:** *Please circle one.*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Do you live at the same address? Y N

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**EMERGENCY:** *Name and address of nearest relative or friend not living with you:*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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**INSURANCE:** *Please present your insurance card(s) to the receptionist.*

Insured's Name: \_\_\_\_\_ Insured's date of birth: \_\_\_ / \_\_\_ / \_\_\_\_\_

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**RESPONSIBLE PARTY:** *Fill out if you are not the patient but are responsible for the bill.*

Responsible Party: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_

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

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Email \_\_\_\_\_ What is the best way to contact you? \_\_\_\_\_

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**SIGNATURE:** (Patient, Parent, Legal Guardian or Responsible Party)

I request services X \_\_\_\_\_

Today's date: \_\_\_\_\_

**Patient Information:**

Legal Name First: \_\_\_\_\_ Last: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Medical History:**

Currently, what are your most important health concerns?

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Are you currently receiving health care? Yes / No

If yes, where, and from whom? \_\_\_\_\_

If no, when, where, and why did you last receive health care? \_\_\_\_\_

**Medication History:**

Please list type and dosage of any prescription or over the counter medications, vitamins or other supplements you are currently taking. Please attach a list if necessary.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list type, dosage and time frame for any prescription or over the counter medication you have regularly taken in the past. (ex: steroid 2x/day- asthma 1972-1976, advil- back pain 1997-1999.)

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Medication Allergies:** \_\_\_\_\_

**X-rays and Special Studies:**

If you have had any imaging studies (x-ray, ultra sound, MRI, DEXA etc) or special testing done list the test, approximate date, and outcome.

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|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Injuries/Surgeries, Hospitalizations:** Please list type of surgery and approximate date.

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|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Patient's Initials \_\_\_\_\_

**Immunizations:**

Are there any recommended immunizations you have not had? \_\_\_\_\_

Have you ever had an adverse (bad) reaction to an immunization? Y / N

**Which childhood diseases have you had?** Ex. measles, chicken pox etc.

\_\_\_\_\_  
 \_\_\_\_\_

**Family Medical History: IF KNOWN.** (If you were adopted, please check here: \_\_\_\_\_)

Please specify M=mother, F=father, S=sister, B=brother A=aunt, U=uncle, PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies or hay fever _____	High Cholesterol _____
Arthritis _____	Cancer _____
Heart Attack _____	Diabetes _____
High blood pressure _____	Other _____

**Review of Systems:** *Although this section is lengthy, it assures that as much time as needed during the visit to address current concerns. It also allows the physician to make possible connection between symptoms that have not been noted before. Thank you for your patience.*

**Please circle: Y = current condition, N = never had this condition, P = past condition**

**Emotional**

History of counseling	Y	N	P	Eating disorder	Y	N	P
Mood swings or depression	Y	N	P	Anxiety	Y	N	P
Considered/attempted suicide	Y	N	P	Tension or nervousness	Y	N	P

**Endocrine**

Thyroid problems	Y	N	P	Heat or cold intolerance	Y	N	P
High blood sugar	Y	N	P	Diabetes	Y	N	P
Low blood sugar	Y	N	P	Excessive thirst or hunger	Y	N	P

**Neurologic**

Seizures	Y	N	P	Loss of balance	Y	N	P
Muscle weakness	Y	N	P	Vertigo or dizziness	Y	N	P
Loss of memory	Y	N	P	Numbness or tingling	Y	N	P
Paralysis	Y	N	P	Fainting	Y	N	P

**Nose and Sinuses**

Sinus pain	Y	N	P	Post nasal drip	Y	N	P
Sinus infection	Y	N	P	Chronic stuffy nose	Y	N	P
Hay fever/ nasal allergies	Y	N	P	Loss of smell	Y	N	P

Patient's Initials \_\_\_\_\_

**Eyes/Ears**

Floaters/ spots	Y	N	P	Eye pain/strain	Y	N	P
Corrective lenses	Y	N	P	Tearing or dryness	Y	N	P
Blurriness or double vision	Y	N	P	Glaucoma or cataracts	Y	N	P
Hearing impairment	Y	N	P	ringing in ears	Y	N	P
Excessive ear wax	Y	N	P	Pain in ears	Y	N	P

**Mouth and Throat**

Frequent sore throat	Y	N	P	Hoarse voice	Y	N	P
Grinding teeth: awake or asleep	Y	N	P	Excess saliva or dry mouth	Y	N	P
Gum problems	Y	N	P	Mouth sores: inside or out	Y	N	P

**Respiratory**

Cough	Y	N	P	Shortness of breath	Y	N	P
Tuberculosis	Y	N	P	Wheezing or Asthma	Y	N	P
Pain with breathing	Y	N	P	Bronchitis	Y	N	P

**Urinary/Kidney**

Painful urination	Y	N	P	Inability to hold urine	Y	N	P
Increased frequency (day or night)	Y	N	P	Kidney stones	Y	N	P
Urgency	Y	N	P	Urinary tract infections	Y	N	P

**Skin**

Rashes/eczema	Y	N	P	Lumps	Y	N	P
Acne or boils	Y	N	P	Itching or fungus	Y	N	P
Color Change	Y	N	P	Psoriasis	Y	N	P

**Head**

Headaches	Y	N	P	TMJ issues	Y	N	P
Head Injury	Y	N	P				

**Cardiovascular**

Heart Disease	Y	N	P	Problems with veins	Y	N	P
Murmur or valve problems	Y	N	P	Chest Pain	Y	N	P
Blood Clots	Y	N	P	High Blood pressure	Y	N	P
Palpitations or fluttering	Y	N	P	Low blood pressure	Y	N	P

**Gastrointestinal**

Trouble swallowing	Y	N	P	Change in bowel habits	Y	N	P
Liver disease	Y	N	P	Change in appetite	Y	N	P
Nausea or vomiting	Y	N	P	Heartburn or ulcer	Y	N	P
Pain or cramps	Y	N	P	Diarrhea	Y	N	P
Black, green, or white stool	Y	N	P	Constipation	Y	N	P
Hemorrhoids or blood in toilet	Y	N	P	Gallbladder disease	Y	N	P
How often do you have a bowel movement?							

**Immune**

Chronic Fatigue Syndrome	Y	N	P	Get sick often	Y	N	P
Chronically swollen glands	Y	N	P	Autoimmune disease	Y	N	P
Slow wound healing	Y	N	P	Frequent infections	Y	N	P

**General Reproductive**

Are you sexually active?	Y	N	P	Sexual orientation			
Chlamydia or gonorrhea	Y	N	P	Low sex drive	Y	N	P
Herpes	Y	N	P	Genital warts	Y	N	P
Type of contraception (if applicable.)							
Have you been recently tested for sexually transmitted diseases?							
Would you like to be tested for sexually transmitted diseases?							

**Female Reproductive**

Sexual orientation				Are you still menstruating	Y	N	
Regular menstrual cycles (timing)	Y	N	P	First day of last menstrual cycle			
How many days between the first day of one cycle and the first day of the next cycle?							
How many days of bleeding (typically)?							
Pain or cramps	Y	N	P	PMS	Y	N	P
Clotting	Y	N	P	Heavy flow	Y	N	P
Abnormal pap smear	Y	N	P	Endometriosis	Y	N	P
Ovarian cysts	Y	N	P	Yeast infection	Y	N	P
Menopausal symptoms	Y	N	P	Vaginitis (gardnerella or BV)	Y	N	P
Nipple discharge	Y	N	P	Breast pain	Y	N	P
Have you adopted any children?	Y	N		Monthly self breast exam?	Y	N	P
# pregnancies				# miscarriages			
# abortions				# live births			

**Male reproductive**

Hernia	Y	N	P	Testicle pain	Y	N	P
Premature ejaculation	Y	N	P	Testicle lump	Y	N	P
Prostate problems	Y	N	P	Impotence	Y	N	P

**Musculoskeletal**

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Muscle pain, spasm, or cramping	Y	N	P
Low bone density	Y	N	P	Nerve pain	Y	N	P

**Other**

Cancer	Y	N	P	Anemia	Y	N	P
Bruising	Y	N	P	Swelling	Y	N	P
Any other condition/s not mentioned?							

Patient's Initials \_\_\_\_\_

**Habits**

Main interests and hobbies:					
Regular exercise	Y	N	P	Hours of exercise per week	
Quality sleep	Y	N	P	Average hours of sleep per night	
Enjoyable work	Y	N	P	Is your work stressful?	Y N
Spiritual practice	Y	N	P	Type of spiritual practice?	
How much TV do you watch daily?				Physical or sexual abuse	Y N P
Regular vacations	Y	N		Supportive relationship	Y N
Recreational drugs	Y	N	P	Personal history of addiction	Y N
Do you think you're overweight?	Y	N		Do you think you're underweight?	Y N
Cups coffee per day:	Cups tea per day:			Amt of soda per day:	
How much water do you drink on an average day?				Tap / Filtered / Bottled	
Food intolerances (if known):					

**A few final questions:**

1. How does your current state of health affect your day to day life?

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2. How would your life be different if you felt 100%?

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For questions 3 and 4, please use a scale of 1 to 10.

3. How committed are you to improving your health? \_\_\_\_\_

4. How much change are you willing to make at this time for improving your health? \_\_\_\_\_

“The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease.” –Thomas Edison

Patient's Initials \_\_\_\_\_

**Insurance & Financial Policies**  
**PLEASE READ THOROUGHLY AND INITIAL BELOW**

If you have questions about any of our financial policies please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

**Insurance:**

In many cases we will be able to call to verify your coverage during your first visit. **If benefits cannot be determined at the time of service and/or if there is any doubt regarding your coverage, payment in full is expected.** If your insurance company remits payment you will be reimbursed when we receive payment. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does *not* guarantee payment as it is possible for an insurance company to misquote coverage. We strongly recommend reviewing your policy to confirm that the information we received is correct. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your policy.

**Initial here \_\_\_\_\_**

It is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days). If we are having trouble getting payment within this time frame and you would like us to continue to pursue billing your insurance company, we will require payment for the visit, verbal confirmation from you, and a \$15 per claim fee in order to help defray the costs of completing the payment.

**Initial here \_\_\_\_\_**

**Supplements:**

Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are happy to take a return if the safety seal has not been broken, and it is within 60 days of date of purchase. Please note that there is no requirement to purchase recommended supplements from our office; there are several local stores or web stores that may carry similar products.

**Initial here \_\_\_\_\_**

**Late Cancellation/Missed Appointments:**

**There will be a \$50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice.** After two missed appointments, you will be charged for the entire time reserved for you on the schedule. If you are scheduled for naturopathic and acupuncture on one day, this is considered two appointments as two slots have been reserved on the schedule. Please note that we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.

**Initial here \_\_\_\_\_**

**Methods of Payment:**

We accept cash, checks, debit, Visa, and MasterCard. There is a \$25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made.

**Authorizations:**

- I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.
  
- I authorize the release of any medical or other information necessary to process any claims.
- I authorize payment of benefits to Evergreen Natural Health Center for all services rendered.

**Patient's or Authorized Person's Signature:**

Name (please print): \_\_\_\_\_

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

**PATIENT NOTICE OF PRIVACY POLICY**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED,  
AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.**

**Patient Rights, Uses and Disclosures of Health Information:**

During the course of your care with Evergreen Natural Health Center we may use or disclose personal and health-related information.

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

**Physician Legal Duties:**

We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

**Complaints and Questions:**

If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact us at 503.977.0500. This notice and any alterations or amendments will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name (please print)                      Signature    Date

*If patient is a minor, or if patient is being represented by another party, your representative signs below:*

\_\_\_\_\_  
Personal Representative (please print)      Personal Representative Signature    Date