



west seattle  
**NATURAL  
MEDICINE**

**Date:** \_\_\_\_\_ Mr. Mrs. Ms. Miss **Marital Status:** M S W D P

**Name:** \_\_\_\_\_  
First Name Middle Initial Last Name

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone (Home):** \_\_\_\_\_ **(Work/Cell):** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**Sex:** M F **Age:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**In Case of Emergency: Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**What other healthcare are you currently receiving?** \_\_\_\_\_

**Date of last Physical Exam:** \_\_\_\_\_

A note to our patients: Naturopathic, holistic and preventative healthcare are only possible when the physician has a complete picture of the patient mentally, physically and emotionally. Please complete the questionnaire as thoroughly as possible. Thank You.

**Present Health Concerns:** In your opinion, what are your most important health concerns (in order of importance)? Also please indicate the problem that motivated you to come in today.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Your Health History: Your health as a child was?** Good Fair Poor **Childhood Illnesses:**

Mumps Pertussis Measles Rheumatic Fever Chicken Pox Diphtheria German Measles

**Surgeries** (Year/Type): \_\_\_\_\_

**Serious Illness or Injury** (Year/Cause): \_\_\_\_\_

**Hospitalizations** (Year/Reason): \_\_\_\_\_

**Vaccinations** (Year/Type/Adverse Reaction?): \_\_\_\_\_

**Medications:** Please list all supplements, prescriptions, and non-prescription drugs and their dosage. (pills, liquids, ointments, suppositories, etc.)

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

**Allergies:** List any allergies and their adverse effects (inhalants, food, drugs, chemicals etc.)

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

**Habits: Alcohol:** Y N **What kind and how many per day/week?** \_\_\_\_\_  
**Coffee:** Y N Caffeinated Decaf **Cups per day?** \_\_\_\_\_ **Recreational Drugs:** Y N  
**Tobacco:** Y N **Amount per day/week?** \_\_\_\_\_ **How long ?** \_\_\_\_\_  
**Your Diet: Any diet restrictions or regimen?** \_\_\_\_\_

**Are you satisfied with your diet as it is now?** Y N **Do you eat three meals daily?** Y N

**Do you crave Starches:** Y N **Sweets:** Y N **Salt:** Y N **Fats:** Y N

Please write down two samples of each meal that you eat nearly everyday. Include what you drink with you meals, desserts and snacks:

**Breakfast:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Morning Snack:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Lunch:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Afternoon Snack:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Dinner:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
**Late Snack/Dessert:** 1. \_\_\_\_\_ 2. \_\_\_\_\_

**What type of water do you drink:** Tap Filtered Distilled Well **How many glasses per day?** \_\_\_\_\_

**Do you drink soft drinks?** Y N **How many per day/week?** \_\_\_\_\_ **Other beverages** \_\_\_\_\_  
 \_\_\_\_\_ **Do you salt your food?** Y N **If so, how much?** Light Moderate Heavy

**Do you use artificial sweeteners?** Y N **What kind?** \_\_\_\_\_ **How much?** \_\_\_\_\_

**Describe your appetite in the:** Morning \_\_\_\_\_ Noon \_\_\_\_\_ Evening \_\_\_\_\_

**Sleep: Do you sleep well?** Y N **Wake Rested?** Y N **Average Hours of Sleep (per 24 Hrs.)** \_\_\_\_\_

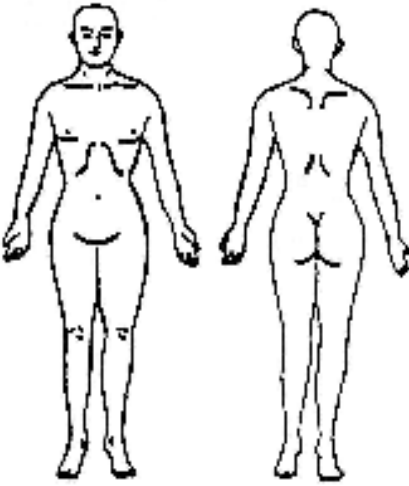
**Exercise: Do you Exercise Regularly?** Y N **What Type?** \_\_\_\_\_  
 \_\_\_\_\_ **How Long?** \_\_\_\_\_ **How Often?** \_\_\_\_\_

<b>Family History:</b>	Father	Mother	Brothers	Sisters	Partner	Children
Age (If Living)						
Heath G-Good, P-Poor						
Age (At Death)						
Cause of Death						

Please identify known conditions within your family and list the family member's relationship to yourself:

**Cancer:** Y N \_\_\_\_\_ **Mental Illness:** Y N \_\_\_\_\_  
**Diabetes:** Y N \_\_\_\_\_ **Heart Disease:** Y N \_\_\_\_\_  
**Stroke:** Y N \_\_\_\_\_ **Glaucoma:** Y N \_\_\_\_\_  
**Hives:** Y N \_\_\_\_\_ **Kidney Disease:** Y N \_\_\_\_\_  
**Asthma:** Y N \_\_\_\_\_ **Tuberculosis:** Y N \_\_\_\_\_  
**Hay Fever:** Y N \_\_\_\_\_ **Physical Abuse:** Y N \_\_\_\_\_  
**Alcoholism:** Y N \_\_\_\_\_ **Emotional Abuse:** Y N \_\_\_\_\_  
**High Blood Pressure:** Y N \_\_\_\_\_ **Other:** \_\_\_\_\_

**Review of Systems:** Please Circle **Y**-For a condition you have now **P**-A condition you have had in the past. **N**-Never had

General:				Wheezing:	Y	P	N	Muscle Spasms/Cramps:	Y	P	N
Weight:	_____			Difficulty Breathing:	Y	P	N	Weakness:	Y	P	N
Weight 1 year ago:	_____			Pain When Breathing:	Y	P	N	Endocrine:			
Max Weight:	_____			Shortness of Breath:	Y	P	N	Thyroid Problems:	Y	P	N
When:	_____			While Lying Down:	Y	P	N	Heat/Cold Intolerance:	Y	P	N
Height:	_____			At Night:	Y	P	N	Hypoglycemia:	Y	P	N
Night Sweats:	Y	P	N	Positive TB test:	Y	P	N	Excessive Thirst:	Y	P	N
Fatigue:	Y	P	N	Heart:				Excessive Hunger:	Y	P	N
Skin:				Heart Disease:	Y	P	N	Easy Weight Gain:	Y	P	N
Rashes:	Y	P	N	High Blood Pressure:	Y	P	N	Breasts:			
Inflammation:	Y	P	N	Chest Pain:	Y	P	N	Regular Self Exam:	Y	P	N
Infection:	Y	P	N	Swelling in ankles:	Y	P	N	Lumps:	Y	P	N
Growths:	Y	P	N	Palpitations/Fluttering:	Y	P	N	Pain/Tenderness:	Y	P	N
Change in hair or nails:	Y	P	N	Digestion:				Nipple Discharge:	Y	P	N
Head:				Trouble Swallowing:	Y	P	N	Emotional:			
Headache:	Y	P	N	Heartburn:	Y	P	N	Depression:	Y	P	N
Head Injury:	Y	P	N	Stomach Pain:	Y	P	N	Mood Swings:	Y	P	N
Ears:				Change in Thirst:	Y	P	N	Anxiety/Nervousness:	Y	P	N
Impaired Hearing:	Y	P	N	Change in Appetite:	Y	P	N	Tension:	Y	P	N
Ringings:	Y	P	N	Nausea:	Y	P	N	Optional: Sexual Preference:			
Ache or Itch:	Y	P	N	Vomiting:	Y	P	N	Heterosexual	Bisexual	Homosexual	
Dizziness:	Y	P	N	Loose Stools:	Y	P	N	Indicate with diagram any problem areas:			
Eyes:				Blood In Stools:	Y	P	N				
Impaired Vision:	Y	P	N	Belching/Gas:	Y	P	N				
Eye Pain:	Y	P	N	Liver Disease:	Y	P	N				
Tearing/Dryness:	Y	P	N	Gall Bladder Disease:	Y	P	N				
Double Vision:	Y	P	N	Hemorrhoids:	Y	P	N				
Nose & Sinus:				Bowels Move:	daily	more	less	<b>Reproductive Health</b> Are you sexually Active: Y P N Sexual Difficulties: Y P N Sexually Transmitted Disease: Y P N Discharge/Sores: Y P N Difficulty Urinating: Y P N Male Reproduction: Hernia: Y P N Testicular Pain: Y P N Testicular Masses: Y P N Prostate Problems: Y P N			
Frequent Colds:	Y	P	N	Urinary:							
Nose Bleeds:	Y	P	N	Pain on Urination:	Y	P	N				
Stiffness:	Y	P	N	Increase Frequency:	Y	P	N				
Sinus Problems:	Y	P	N	Frequency at Night:	Y	P	N				
Post Nasal Drip:	Y	P	N	Inability to Hold Urine:	Y	P	N				
Mouth & Throat:				Bladder Infections:	Y	P	N	<b>Reproductive Health</b> Are you sexually Active: Y P N Sexual Difficulties: Y P N Sexually Transmitted Disease: Y P N Discharge/Sores: Y P N Difficulty Urinating: Y P N Male Reproduction: Hernia: Y P N Testicular Pain: Y P N Testicular Masses: Y P N Prostate Problems: Y P N			
Frequent Sore Throat:	Y	P	N	Circulation:							
Sore Tongue:	Y	P	N	Deep Leg Pain:	Y	P	N				
Sores on Mouth/Lips:	Y	P	N	Cold Hands/Feet:	Y	P	N				
Gum Problems:	Y	P	N	Varicose Veins:	Y	P	N				
Dental Problems:	Y	P	N	Neurological:				<b>Reproductive Health</b> Are you sexually Active: Y P N Sexual Difficulties: Y P N Sexually Transmitted Disease: Y P N Discharge/Sores: Y P N Difficulty Urinating: Y P N Male Reproduction: Hernia: Y P N Testicular Pain: Y P N Testicular Masses: Y P N Prostate Problems: Y P N			
Neck:				Fainting:	Y	P	N				
Swollen Glands:	Y	P	N	Seizures:	Y	P	N				
Pain or Stiffness:	Y	P	N	Paralysis:	Y	P	N				
Blood:				Muscle Weakness:	Y	P	N				
Anemia:	Y	P	N	Numbness/Tingling:	Y	P	N	<b>Reproductive Health</b> Are you sexually Active: Y P N Sexual Difficulties: Y P N Sexually Transmitted Disease: Y P N Discharge/Sores: Y P N Difficulty Urinating: Y P N Male Reproduction: Hernia: Y P N Testicular Pain: Y P N Testicular Masses: Y P N Prostate Problems: Y P N			
Easy Bleeding/Bruising:	Y	P	N	Loss of Memory:	Y	P	N				
Respiratory:				Musculoskeletal:							
Cough:	Y	P	N	Joint Pain/Stiffness:	Y	P	N				
Spitting up Blood:	Y	P	N	Broken Bones:	Y	P	N				

**Female Gynecological History:** Date of last period? \_\_\_\_\_ Are you post-menopausal? Y N  
Are you on hormones? Y N If yes, which type? \_\_\_\_\_  
Age menses began? \_\_\_\_\_ Number of days in flow? \_\_\_\_\_ Length of cycle? \_\_\_\_\_  
Regular Cycles? Y N Abnormal discharge? Y N Spotting between periods? Y N  
Do you experience symptoms of? PMS? Y N Cramping? Y N Excessive Flow? Y N  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a history of the following vaginal infections?**

Yeast Infection? Y N Gonorrhea? Y N Syphilis? Y N Herpes? Y N  
Chlamydia? Y N Vaginitis? Y N HPV? Y N  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

**Do you have a history of the following?**

Ovarian Cysts? Y N Uterine Fibroids? Y N Endometriosis? Y N  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Date of last PAP \_\_\_\_\_ Were the results normal? Y N

Have you ever had an abnormal PAP? Y N If so, when \_\_\_\_\_

**Please list the number associated with the following:**

Pregnancies \_\_\_\_\_ Live Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Type of birth control currently in use: \_\_\_\_\_ Past use: \_\_\_\_\_

Any pain during intercourse? Y N Difficulty conceiving? Y N

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

**Do you do a breast self exam regularly? Y N Do you consistently have lumps? Y N**

**Pain or tenderness? Y N Nipple discharge? Y N If yes to any of the above, please describe**  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had a mammogram? Y N If yes, when? \_\_\_\_\_ Normal? Y N**

**Comments your ND should be aware of \_\_\_\_\_**  
\_\_\_\_\_  
\_\_\_\_\_

**Menopausal Symptoms? Y N Please specify \_\_\_\_\_**  
\_\_\_\_\_

## Financial and Referral Policies

The policy of West Seattle Natural Medicine Clinic is to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard. We will bill all insurance companies that we are contracted with. ***It is your responsibility to contact your insurance company prior to your first office call so you know whether our services are covered under your plan.***

All dispensary products will be paid for at the time of pickup. If products are mailed, a Visa or MasterCard number will be required for purchase. Shipping and handling charges will apply. Dispensary products are non-returnable.

All checks returned for non-sufficient funds will result in a \$25.00 service charge to be collected by the next visit or within 30 days (whichever comes first).

If no payment is received on an account after 90 days, the account will be charged an interest rate of 15%. If there is still no payment made to the account after another 30 days the account will be sent to a collection agency.

**Referral Policy:** It is necessary to be seen by the Doctor for a health assessment and diagnosis before a referral can be given. If an emergent situation should arise, a call to request an emergency referral should suffice.

**Note:** A phone visit of greater than 5 minutes is reserved for those unable to get to the clinic, or with emergency needs. It is only for the use of established patients.

We will charge a lab-handling fee when appropriate; otherwise most labs will bill your insurance directly.

A fee of \$25.00 will be charged for cancellations made less than 24 hours from your scheduled appointment. **A no show fee of \$50.00 will be charged for patients who fail to show up for scheduled appointments.** Missed appointment charges are not covered by insurance.

I, \_\_\_\_\_, understand and willing to comply with above fees and payment procedures.

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

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

**Relationship to patient** (circle one):      Self      Parent      Legal Guardian      Spouse      Power of Attorney

## Consent to use/and or Disclose Patient Information

As a patient of West Seattle Natural Medicine Clinic, you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practice before signing this form. A copy of this Notice was made available to you along with this Consent. If you do not have copy of the Notice you can request one from us at the address and phone number given below.

We may change our Notice of Privacy Practice from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you are in the office for an appointment. You may obtain a copy of our current Notice upon request to our address or phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practice explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care and conduct certain kinds of administrative information about you these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number below if you want more information, or to revoke this Consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment and health care operations.

Patient Signature: \_\_\_\_\_

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