True North Health Solutions

955 W. Orchard Ave, Ste. A, Hermiston, OR 97838

☎: 541-289-1637 |🖷: 541-567-2552 | ✉: truenorth@eotnet.net | 💻: truenorthhealthsolutions.com

Patient Registration Form

Thank you for inquiring into our clinic. Our clinician (psychiatric nurse practitioner, family nurse practitioner, therapist, counselor) is trained, licensed and/or board certified in their respective profession. The clinician chooses which insurance panels they accept and which clients they feel they will be able to best serve, considering their present caseload. Please complete this information and return form to True North Health Solutions, either by one of the below listed methods at least 1 week prior to your appointment:

- Mail/Hand Deliver: 955 W. Orchard Ave, Suite A, Hermiston, OR 97838
- Email: truenorth@eotnet.net
- Fax: 541-567-2552

The practitioner will need to review this information to determine eligibility and you will be notified by phone if we need to refer you to a clinic that could better serve you. We will call to reschedule your appointment if we have not received this information 1 week prior to your initial appointment, unless other arrangements have been approved.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

While this clinic recognizes many sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Office Location

True North Health Solutions
955 W. Orchard Ave, Suite A
Hermiston, OR 97838

Patient Demographics

Patient Name		Date of Birth	Age	Sex Select	Marital Status Select
SSN#	Address	City	State		Zip Code
Home Phone#	Cell Phone#		Work Phone#		
How Did You Hear About True North?		What are you seeking?			
Emergency Contact		Relationship	Emergency Phone#		
Primary Care Physician	Phone#		Fax#		
Address		City	State		Zip Code

Insurance Information: ***(Please Provide copy of Card(s) prior to appointment to prevent cash payment required)***

Name of Insured Person	Relationship to Patient Select	Birthdate of Insured Person	SSN#
Insurance Company	Group#	Policy/ID#	Insurance Company#
Insurance Company Address		City	State / Zip Code

Do you have separate Medication Insurance Card or Secondary Insurance? If Yes, please provide information:

Name of Insured Person	Relationship to Patient	Birthdate of Insured Person	Ins. Person SSN#
Insurance Company	Group#	Policy/ID#	Insurance Company Ph#
Insurance Company Address		City	State / Zip Code

Chief Complaint: In Your own words, describe the reason for your desired visit:

Current Medications/ Supplements

(Please bring all medications in their original bottles to first appointment)

Are You Taking Any Prescribed Medications or Supplements? If Yes, please list all current medications & supplements that you take				Select
Name of Medication & Dosage	Frequency	Reason Prescribed	Prescribed by	Date Began

Pharmacy Information

Name of Pharmacy	Phone#		Fax#	
Address		City	State	Zip Code

History of Present & Past Psychiatric History

Current Symptoms	Date Symptoms Started	How long symptoms have lasted?
Appetite:	Sleep Pattern:	

Pain

Do you experience chronic pain? NO	If yes, where?
If yes, how is pain managed & by whom?	Who is managing you pain medications?

On a scale of 0 to 10 with 10 being the worst and 0 being no pain, how would you rate your current level of pain?

(Least Pain) (Worst Pain)

0 1 2 3 4 5 6 7 8 9 10

0

Health Information

Medical Conditions	Yes/No	Concerns	Medical Conditions	Yes/No	Concerns
Anemia	Select		Home Safety		
Asthma	Select		Kidney Problems		
Cancer	Select		Migraine Headache		
Diabetes	Select		Other		
Diet/Nutrition	Select		Oxygen Dependent		
Emphysema	Select		Prostate		
Glaucoma	Select		Sleep Apnea		
Hearing Loss	Select		Sexual		
Heart Disease	Select.		Stomach Problems		
High Blood Pressure	Select.		Stroke		
High Cholesterol	Select.		Thyroid		

Do you smoke tobacco?	Select	Times per day		For	# of Years	Year Quit	
Do you chew tobacco?	Select	Times per day		For	# of Years	Year Quit	
Do you drink?	Select	Times per day		For	# of Years	Year Quit	
Do you use any nonprescribed drugs?	Select	What is your occupation?					
Do you get regular exercise?	Select	Type?		Amount?			

Allergies

Allergy	Reaction	Severity

Surgical History

Surgery	Year	Surgery	Year

Preventative Care (Year of last vaccine)

	Pneumonia		Tetanus		Flu		Shingles

Year of last procedure/exam:

Pap Smear	Colonoscopy	Physical Exam
Mammogram	Bone Density Test	Prostate Test/Exam

Significant Family History (include family member)

Continued Symptoms List:

DEPRESSION Select. Select.	ANXIETY
PANIC ATTACKS Select. Select.	ANOXERIA/BULMIA
ECT TREATMENTS	SOCIAL PHOBIA
ADHD	OCD
PTSD/TRAUMA	BINGE EATING
BIPOLAR DISORDER	TEST ANXIETY
SCHIZOPHRENIA	ALCOHOL
DRUG PROBLEMS	ABUSE
PRESONALITY DISORDER	OTHER:

Suicide/Homicide/Self Harm Current & History

Current Suicide (hurting self) thought, ideas, or plans? Select.	
If Yes, what is stopping you from acting upon these thoughts, ideas, plans?	
History of Suicide (Hurting self) thought, ideas, or plans: Select.	Attempts? Select.
Suicide Plan in Place? Select If yes, with who and describe:	

History of Homicidal (Hurting others) thought, ideas, or plans: Select			Attempts? NO		
Self-Harm **History:**	Select Cutting	Select Pulling Hair	Select Withholding food	Select Binging	Select Purging
Other:					

If yes, to any of the above: List dates and method:			
Method:	Date:	Method:	Date:
Method:	Date:	Method:	Date:
Method:	Date:	Method:	Date:
Method:	Date:	Method:	Date:
Method:	Date:	Method:	Date:

CRISIS HOTLINE 24 HOURS UMATILLA COUNTY

1-866-343-4473

Past Treatment Modalities/Interventions: (Check those that apply)

Inpatient Treatment:		
Where:	When:	Outcome:
Where:	When:	Outcome:
Where:	When:	Outcome:
Outpatient Treatment:		
Where:	When:	Outcome:
Where:	When:	Outcome:
Where:	When:	Outcome:
Complementary Treatment such as: Acupuncture NET MNT Chiropractic Other		
Where:	When:	Outcome:
Where:	When:	Outcome:
Where:	When:	Outcome:
ECT Treatment:		
Where:	When:	Outcome:
Where:	When:	Outcome:
Where:	When:	Outcome:

What is your employment status?

Employed (Where & What do you do?)	
If retired, where from & when?	
Unemployed? Select	How long?

Are you receiving or applying Medicaid or any form of short or long-term disability?

(This clinic does NOT specialize in assessments for Long Term Disability, Short Term Disability is assessed as needed for treatment only)

Legal Issues?	If Yes, please describe:

Trauma History (Are/Were you a victim of any form of physical/sexual/emotional abuse?)

Physical Abuse:	Yes	No	Age(s) of Occurrence:
Sexual Abuse:	Yes	No	Age(s) of Occurrence:
Emotional Abuse:	Yes	No	Age(s) of Occurrence:
Traumatic Brain Injury	Yes	No	Age of Occurrence:
Other:			

Level of Education

Name of school (if currently attending)	Last Grade Attended	Phone#

Social History

Where were you born?		Where did you grow up?
How many siblings do you have?	Brothers#	Sisters#
Are you currently involved in a romantic relationship?		How long?
Spouse/Partner's Name:		Age of Spouse/Partner?
How many children do you have?	Sons#	Daughters#
Do you feel like you have a strong support system (family, friends)?		

Women's Gynecologic History

# of Pregnancies	# of Deliveries	# of Abortions	# of Miscarriages
Are you currently on birth control?		If yes, which one?	