ELLIOTT BAY NATURAL MEDICINE Paul Dompé, N.D.

1904 THIRD AVE SUITE 808 SEATTLE, WA 98101 T206.816.3433

## Health History Questionnaire

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. **All of your answers will be held absolutely confidential.** If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Date:_________________________

Name: ___________________________________Age_____________ Date of Birth: _______________

Street:_____________________________________City:_____________State:____Zip:_____________

Home Phone: ___________________________ Work phone: __________________________________

Do we have your permission to call you at home and/or work? Yes No

Email:_________________________________________

Employer: ______________________________Circle one: married single significant other

Do you have any children? Yes No If so, please list their ages____________________________________

In case of emergency notify:_____________________Relationship___________Phone:____________________

Referred by:_______________________________ Family Physician: ___________________________

What are your goals for today's visit?____________________________________________________________

**Main problem(s) you would like to address:**

___________________________________________________________________________________________

___________________________________________________________________________________________

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _________________________

___________________________________________________________________________________________

How long has it been since you first noticed any symptoms? ________________________________________

Have you been given a diagnosis for the problem by a physician? ____________________________________

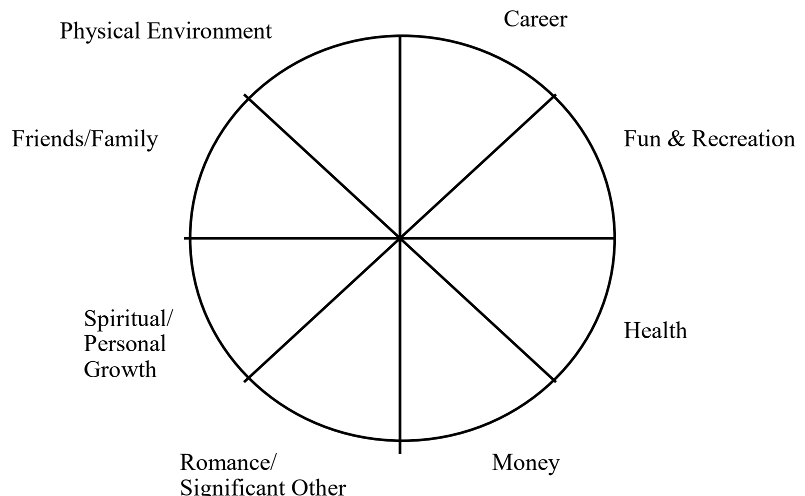
If yes, what was the diagnosis? ______________________________________________________________

What kind of treatments have you tried for this problem? _________________________________________

**WHEEL OF BALANCE**

Wellness is a balance of many factors. Using the circle, starting with the center and moving outwards, shade your level of Satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.



**Past Medical History (please include dates of 1st diagnosis):**

□ Allergies: □ Cancer □ Diabetes

□ Hepatitis □ High Blood Pressure □ Heart Disease

□ seizures □ Surgeries □ Thyroid disease

□ Other significant illness (please describe): ______________________________

□ Accidents, significant trauma, or hospitalizations______________________________

Other relevant Past Medical History: ______________________________

______________________________

______________________________

**Occupation:** ______________________________

Occupational stress factors (physical, psychological, chemical): ______________________________

______________________________

______________________________

**Lifestyle:**

Do you follow a regular exercise program?_______ If so, please describe: ______________________________

______________________________

______________________________

Food sensitivities______________________________

Water intake: ______________________________

□ Smoke cigarettes _________# per day How long have you smoked? ______________________________

□ Drink coffee _________cups per day □ Drink tea type: __________ __________cups per day

□ Drink soda _________amt. Per day □ Drink alcohol type:______________________________

______________________per day/ week/ month (circle one)

Medications taken within the last two months (vitamins, prescription and over-the-counter drugs, herbs, etc.):

______________________________

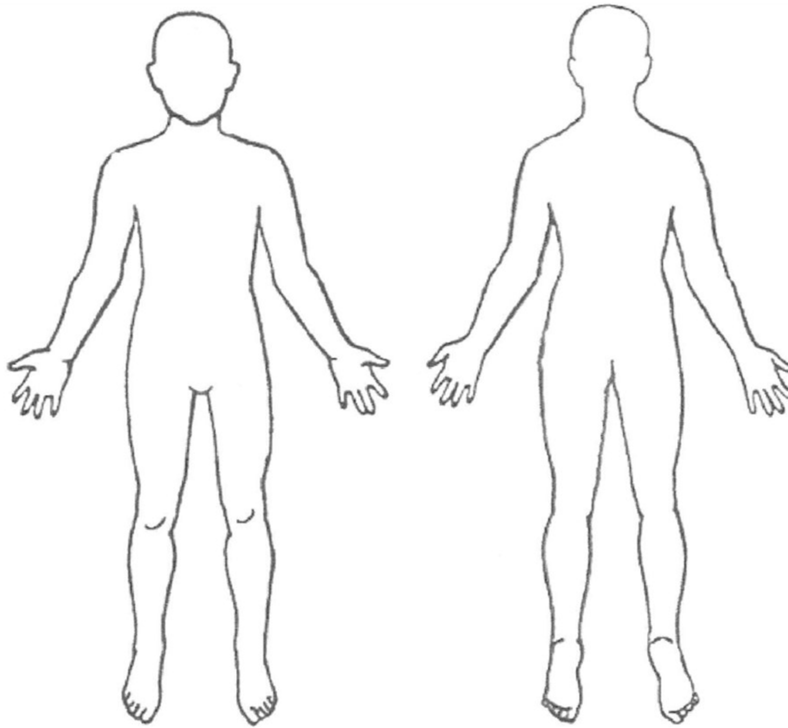
______________________________

______________________________

______________________________

Please describe any use of drugs for non-medical purposes: ______________________________

**Indicate painful or distressed areas:**



**Please put a check next to conditions you have experienced <u>within the last three months</u>. Indicate the length of time you have had this condition:**

## General:

□ Poor appetite
□ Localized weakness
□ Weight gain
□ Sweating easily
□ Night sweats
□ Sudden energy drop (time of day)?_______________
□ Insomnia
□ Cravings
□ Weight loss
□ Tremors
□ Fever
□ Dream disturbed sleep
□ Strong thirst
□ Changes in appetite
□ Bleeding or bruising easily
□ Chills
□ Poor balance
□ Other unusual or abnormal conditions you have noticed in your general sense of health?_________________

**Please put a check next to conditions you have experienced within the last three months. Indicate the length of time you have had this condition:**
**Cardiovascular:**

| | Mother | Father | Sister | Brother | Spouse | Child | Other |
|---|---|---|---|---|---|---|---|
| Age (if living) | | | | | | | |
| Age (at death) | | | | | | | |
| Cause of death | | | | | | | |
| Health G=good P=poor | | | | | | | |
| Cancer | | | | | | | |
| Diabetes | | | | | | | |
| Heart Disease | | | | | | | |
| High Blood Pressure | | | | | | | |
| Stroke | | | | | | | |
| Epilepsy | | | | | | | |
| Mental Illness | | | | | | | |
| Asthma, Hayfever, Hives | | | | | | | |
| Anemia | | | | | | | |
| Kidney Disease | | | | | | | |
| Glaucoma | | | | | | | |
| Tuberculosis | | | | | | | |
| Syphilis | | | | | | | |
| Others | | | | | | | |

## Comments:

Please tell us of any other problems you would like to discuss________________________________________

______________________________________________________________________

______________________________________________________________________

____________________________________________________________________

______________________________________________________________________

____________________________________________________________________

## Psychological:

Have you ever received professional support for your mental health?__________________________________________

Sometimes things happen that are unusually or especially frightening, horrible, or traumatic. For example,

- A serious accident or fire.
- A physical or sexual assault or abuse.
- An earthquake or flood.
- A war.
- Seeing someone be killed or seriously injured.
- Having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? □ Yes □ No

If yes, please answer the questions below:

In the past month, have you…

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
   □ Yes □ No
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   □ Yes □ No
3. Been constantly on guard, watchful, or easily startled?
   □ Yes □ No
4. Felt numb or detached from people, activities, or your surroundings?
   □ Yes □ No
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   □ Yes □ No

# PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

## A

| During the last 4 weeks, how much have you been bothered by any of the following problems? | (0) Not Bothered | (1) Bothered a little | (2) Bothered a lot |
|---|---|---|---|
| 1.Stomach pain | ☐ | ☐ | ☐ |
| 2.Back pain | ☐ | ☐ | ☐ |
| 3.Pain in your arms, legs, or joints (knees, hips, etc.) | ☐ | ☐ | ☐ |
| 4.Feeling tired or having little energy | ☐ | ☐ | ☐ |
| 5.Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ |
| 6.Menstrual cramps or other problems with your periods | ☐ | ☐ | ☐ |
| 7.Pain or problems during sexual intercourse | ☐ | ☐ | ☐ |
| 8.Headaches | ☐ | ☐ | ☐ |
| 9.Chest pain | ☐ | ☐ | ☐ |
| 10.Dizziness | ☐ | ☐ | ☐ |
| 11.Fainting spells | ☐ | ☐ | ☐ |
| 12.Feeling your heart pound or race | ☐ | ☐ | ☐ |
| 13.Shortness of breath | ☐ | ☐ | ☐ |
| 14.Constipation, loose bowels, or diarrhea | ☐ | ☐ | ☐ |
| 15.Nausea, gas, or , indigestion | ☐ | ☐ | ☐ |
| PHQ-15 Score: | | | |

B

| During the last 2 weeks, how often have you been bothered by the following problems? | (0) Not at all | (1) Several Days | (2) More than half the days | (3) Nearly every day |
|---|---|---|---|---|
| 1.Feeling nervous, anxious, or on edge | ☐ | ☐ | ☐ | ☐ |
| 2.Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| 3.Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| 4.Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| 5.Being so restless that it is hard to sit still | ☐ | ☐ | ☐ | ☐ |
| 6.Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| 7.Feeling afraid as if something awful might happen | ☐ | ☐ | ☐ | ☐ |
| **GAD-7 Score** | | | | |

C

| Questions about anxiety attacks. | NO | YES |
|---|---|---|
| a.In the last 4 weeks, have you had an attack – suddenly feeling fear or panic? | ☐ | ☐ |
| **If you have checked "NO", go to question E.** | | |
| b.Has this ever happened before? | ☐ | ☐ |
| c.Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable? | ☐ | ☐ |
| d.Do these attacks bother you a lot or are you worried about having another attack? | ☐ | ☐ |
| e.During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping? | ☐ | ☐ |

**D**

| During the last 2 weeks, how often have you been bothered by the following problems? | (0) Not at all | (1) Several Days | (2) More than half the days | (3) Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |
| | **PHQ-9 Score:** | | | |

**E**

If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

ELLIOTT BAY NATURAL MEDICINE Paul Dompé, N.D.

1904 Third Ave Suite 808 Seattle, WA 98101 T (206) 816-3433 F (206) 816-3423

**INFORMED CONSENT FOR TREATMENT**

I, ______________________________, hereby authorize the practitioners of the Elliott Bay Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Medicinal use of nutrition**: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
**Botanical medicine**: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.

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**Lifestyle counseling and hygiene**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

**Psychological Counseling:** the examination of cognitive (thoughts and beliefs), affective (emotions), and behavioral patterns.

**Biofeedback Therapy:** use of sensors and software to acquire physiological data used to learn self-regulation.

**I recognize the potential risks and benefits of these procedures as described below:**
**Potential risks**: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

**Potential benefits**: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**Notice to Pregnant Women**: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Elliott Bay Natural Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that my case may be discussed (without identifying information) for educational purposes. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

________________________ ________________________________________
Date Signature of Patient

________________________________________
Signature of Patient Representative

# FINANCIAL POLICY AND INSURANCE COVERAGE

Welcome to Elliott Bay Natural Medicine. Thank you for choosing us as one of your health care providers. Please take a few minutes to read this information. It contains many of our basic business policies and is designed to assist you in your health care interactions with our clinic. Please feel free to call us at 206-816-3433 and talk to the receptionist if you need clarification on any of these issues.

## PAYMENT

Elliott Bay Natural Medicine requires all patients provide a valid credit card on file and authorization to automatically bill any balance to the credit card related to an unmet deductible, co-insurance, or non-covered services to the credit card on file. If you do not have insurance coverage, or we are not yet billing your insurance company, we appreciate your payment in full at the time of service. The clinic accepts cash, checks, debit cards, and most major credit cards. Insurance co-pay and/or dispensary items are due at the time of service. Elliott Bay Natural Medicine will bill your insurance company as a courtesy; however, we cannot negotiate disputed claims. It is the patient's responsibility to contact their insurance company to resolve lack of payment issues. Accounts which are past due beyond 60 days are subject to a 1% per month interest charge. Accounts past due more than 90 days are subject to an additional $25 processing fee.

## KNOW YOUR INSURANCE COVERAGE

We encourage you to be informed about the coverage of your health insurance plan including annual deductible, copays, coinsurance, and any possible services that require authorization or services that are not covered by insurance can help prevent an unexpected bill. To assist you, please see the Insurance Benefit Inquiry below to help keep you informed. For accurate and timely billing, it is important to update us with any changes to your health plan.

## CANCELLATION/MISSED APPOINTMENT POLICY

We require notification 24 hours in advance if you cannot keep your appointment. Failure to comply with this policy will result in a charge on your credit card on file. There will be a $90.00 charge for cancelled appointments with less than 24 hours' notice. There will be a $50.00 charge for late arrivals greater than or equal to 15 minutes. The appointment fee will be charged for a no show or failure to inform our office of cancellation.

## MEDICAL RECORDS

Please be aware that we are unable to supply medical records, including lab results, on a walk-in basis. In all cases a medical records release form must be filled out, including patient signature and complete date, for us to comply with the law and protect your confidentiality. Requests will be processed, and records mailed out within 10 working days. There is no charge for records mailed directly to other health care providers. However, there may be a charge for records released directly to a patient.

## FINANCIAL POLICY AND INSURANCE COVERAGE
## (Continued)

MIND-BODY MEDICINE/BIOFEEDBACK

Although office visits are typically covered by insurance plans, some mind-body medicine intervention services, including but not limited to biofeedback therapy and neuromuscular re-education, are considered by insurance companies to be medically unnecessary and therefore are not covered by insurance. **Patients receiving biofeedback are directly responsible for the amount of $75 due for mind-body medicine interventions, including biofeedback therapy, in addition to any copay or co-insurance amount due.** We require all patients authorize Elliott Bay Natural Medicine to bill their credit card on file for all services rendered by signing below.

***I acknowledge that I have read and understand the above information. I agree to the above fee and charge policies.*** I agree to pay, in a current manner, any balance of said professional service charges not covered by insurance payment. I agree that if I receive biofeedback therapy, I do not wish the service be billed to my health insurance plan. I agree to be responsible for the amount due in addition to any copay or co-insurance amount due. This authorization will become a part of my records.

Patient's Name (please print) ______________________________ Date of Birth_________________

Guarantor (if not patient) ______________________________Relationship to patient_____________

Signature of responsible party______________________________________Date______________

**INSURANCE BENEFIT INQUIRY**

Name of Primary Insurance Carrier: ____________________________________________________

It is helpful to get the name of the person with whom you speak with regarding your benefits and a reference number for the information with which they provided.

Representative name: ___________________________________ Ref#_________________________

Patient Name:__________________________________________ID Number:______________________

Date of Birth:___________________________

Is my insurance contracted with Elliott Bay Natural Medicine?________________

Do I have visit limit per Calendar year?____________________

Calendar Year My deductible is $___________I have met $___________of my deductible for this year.

My out-of-pocket maximum is $__________I have met $____________of my maximum this year.

(Once an out-of-pocket max is reached, insurance will no longer charge a copay or coins)

My co-pay for each visit is $_____________My co-insurance is_________% of the allowed amount.

Some plans require pre authorizations for massage and for certain naturopathic treatments.