ELLIOTT BAY NATURAL MEDICINE

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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:_____ Height:_____ Weight: _____

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? _____

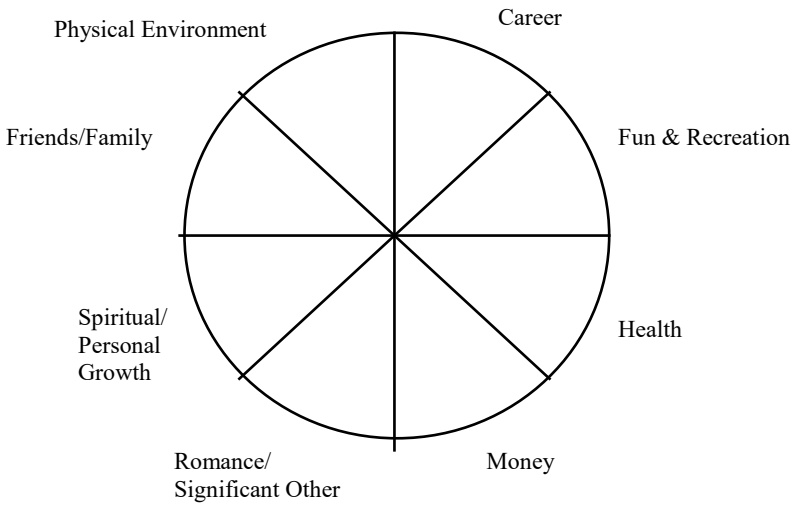
If yes, what was the diagnosis? _____

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):

Birth: Premature___ Breathing problems____ Infections___ Other___

1st year of life: Bellyache___ Colic___ Loose stools___ Blood in stools___

Breast Fed: Y N How long?_____

Health as child: Good Fair Poor

Childhood illnesses: Scarlet fever__ German mealses__ Measles__ Pertussis__ Rheumatic Fever__ Chicken Pox__

Diptheria__ Mumps__ Eczema__ Skin Rash__ Bronchitis__ Ear Infections__ Other__

Vaccinations/immunizations (year, type, adverse reations)_____

_____

□ 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: _____

_____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Other: _____

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.):

_____

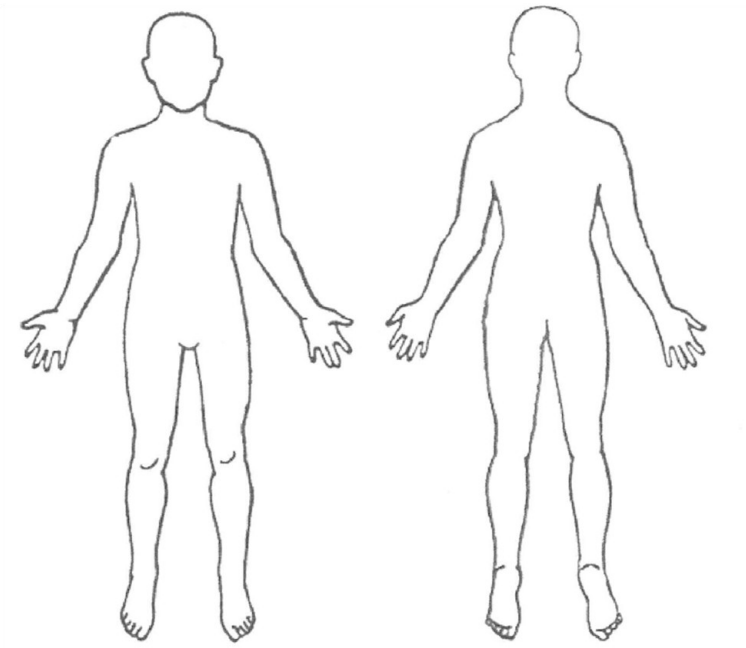
_____

_____

_____

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?_____
_____

Skin and Hair:

□ Rashes
□ Itching
□ Dandruff
□ Changes in hair or skin texture_____
□ Ulcerations
□ Eczema
□ Hair loss
□ Hives
□ Pimples
□ Recent moles
Any other hair or skin problems? _____

Head, Eyes, Ears, Nose, Throat

□ Dizziness
□ Use glasses or contacts
□ Poor vision
□ Cataracts
□ Ringing in ears
□ Sinus problems
□ Grinding teeth
□ Teeth problems
□ Concussions
□ Spots in front of eyes
□ Night blindness
□ Blurry vision
□ Poor hearing
□ Recurrent sore throats
□ Sores on lips or tongue
□ Headaches
□ Migraines
□ Eye pain
□ Color blindness
□ Earaches
□ Eyestrain
□ Nosebleeds
□ Facial pain
□ Jaw clicks
Any other head or neck problems? _____

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:

Cardiovascular:

□ Dizziness upon standing
□ Palpitations
□ Cold hands or feet
□ Blood clots
□ Low blood pressure
□ High blood pressure
□ Swelling of hands
□ Difficulty in breathing
□ Chest pain
□ Fainting
□ Swelling of feet
□ Phlebitis

Any other heart or blood vessel problems? _____

Respiratory:

□ Cough
□ Bronchitis
□ Difficulty breathing when lying down
□ Coughing up blood
□ Pain with deep inhalation
□ Production or phlegm
□ Asthma
□ Pneumonia

Any other lung problems? _____

Gastrointestinal:

□ Nausea
□ Constipation
□ Black stools
□ Bad breath
□ Abdominal pain or cramps
□ Vomiting
□ Gas
□ Blood in stools
□ Rectal pain
□ Diarrhea
□ Belching
□ Indigestion
□ Hemorrhoids

Any other problems with stomach or intestines? _____

Genito-urinary:

□ Pain on urination
□ Urgency to urinate
□ Decrease in flow
□ Frequent urination
□ Unable to urinate
□ Impotence
□ Blood in urine
□ Kidney stones
□ Sores on genitals

Do you wake up at night to urinate? _____If so, how often? _____
Any other problems with your genital or urinary functions? _____

Reproductive and gynecologic:

□ Age of first menses_____
□ Length of cycle_____days
□ Duration of flow_____days
□ Number of pregnancies_____
Births _____
Miscarriages _____
Abortions _____
□ Menopause: Age_____
□ Irregular menses
□ Painful menses
□ PMS symptoms(physical/emotional)
□ Menstrual clots
□ Unusual menses
Heavy or light?_____
□ First day of most recent period_____
□ Do you use birth control? _____
□ If so, what type:_____
_____
□ For how long?_____

Musculoskeletal:

□ Neck pain
□ Shoulder pain
□ Back pain
□ General muscle pain
□ Muscle weakness
□ Hand/wrist pain
□ Knee pain
□ Foot/ankle pain
□ Hip pain

Any other joint, bone, or muscular problems? _____

Neurological:

□ Seizures
□ Areas of numbness
□ Concussion
□ Loss of balance/coordination
□ Short temper
□ Depression
□ Anxiety
□ Poor memory
□ Overwhelmed by stress

Psychological:

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

Over the last 2 weeks, how often have you been bothered by any of the following:

1. Little interest or pleasure in doing things.
   □ not at all □ several days □ more than half the days □ nearly every day

2. Feeling down, depressed, or hopeless.
   □ not at all □ several days □ more than half the days □ nearly every day

Have you ever considered or attempted suicide_____

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

Family Medical History

Check all applicable:

	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_____

_____

_____

_____

_____

_____

NATUROPATHIC MEDICINE
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:

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
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.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Biofeedback therapy
Psychological Counseling
Contraception
Immunization

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, injury from injections, venipuncture or procedures.

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

NEW PATIENT INFORMATION

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 business 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

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. Finance charges are applied to all unpaid balances after 90 days.

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 your being charged for the appointment. There will be a $75.00 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 full fee will be charged for missed appointments.

MEDICAL RECORDS

Please be aware that we are unable to provide 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, in order 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.

LAB CHARGES

The practitioners at Elliott Bay Natural Medicine cannot guarantee insurance coverage for lab fees. Lab test charges are based on the laboratory performing the analysis. Charges for lab work are the responsibility of the patient regardless of insurance coverage.

I acknowledge that I have read and understand the above information. I agree to the above fee and charge policies. I herby instruct and direct my insurance company to pay by check made out to Dr. Paul Dompé for the professional or medical expertise benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the final charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. I agree to pay, in a current manner, any balance of said professional service charges not covered by insurance payment.

Patient's Name (please print)_____ Date of Birth_____

Guarantor (if not patient)_____Relationship to patient_____