NATURAL HEALTH CLINIC
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1707 F Street, Bellingham, WA 98225
(360) 734-1560

Welcome!

Whom may we thank for referring you? _____

Naturopathic physicians are primary health care providers emphasizing optimal health, as well as the natural treatment and prevention of disease.

The goal of your naturopathic physician is to help you enhance the quality of your health and life by working with various treatment modalities such as lifestyle counseling, clinical nutrition, botanical medicine, and homeopathy. Your physician will develop a therapeutic plan that is best suited to you and is most appropriate to your situation. Physicians may perform physical exams and order lab or other studies to gather the information needed to make diagnostic and treatment decisions. Your physician will make referrals to specialists if she believes it is in the best interest of your health.

* *

Initial Free Consultations: (15 minutes) Offered as an introduction to your doctor, and Naturopathy with focus on your particular health problem. This time is not intended for treatment. **If a free consultation is longer than 15 minutes, or culminates in treatment, you will be charged for an office visit.**

Office visits: Charge is based on the complexity of your appointment, and according to allowable standard insurance rates.

Acute care: One of the best benefits of a group practice is that if you have an urgent need, or sudden onsets of symptoms: ear infection, mastitis, or urinary tract infection, for example, you may call for a 5 minute visit with one of our doctors, and we will get you in as soon as possible; usually the same day you call, however it may be with a different doctor than who you've established care with.

Lab and pharmacy: Charges will vary depending on item(s) provided.

Telephone/Email Care: No charge for first 5 minutes. Phone calls that extend beyond 5 minutes will be charged based on office call rates, and cannot be billed to insurance.

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Payment is expected immediately following your visit unless other arrangements have been made with the office manager. If you need to cancel or reschedule your appointment, please give us 24 hours notice. This allows other patients the opportunity to fill your time slot. There will be a $50.00 fee charged for cancellations made with less than 24 hour notice.

Insurance: Please provide office personnel with any insurance information prior to your visit. While many companies do cover naturopathy in whole or part, it is better for all parties for patients to understand coverage in advance. Depending on your coverage, we may ask that you pay for services at the time of the visit and be reimbursed directly by your insurance.

Please feel free to ask questions and offer comments about our services! It is our mission to provide quality health care in a comfortable, supportive environment. Thank you.

I have read this handout explaining fees and services.

Patient Printed Name

Patient signature Date

The Natural Health Clinic
1707 F Street
Bellingham WA 98225
360.734.1560

Patient Name: _____ Date: _____
First Last M.I.
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ Patient's Sex: _____ Marital Status: _____
Telephone Numbers: _____ _____ _____
Home Mobile Work
E-mail Address:_____
Employer: _____ Employer's Address: _____
Primary Care Physician: _____ Referring Physician: _____
Emergency Notify (Name & Relationship): _____ Phone: _____

INFORMATION REGARDING THE INDIVIDUAL RESPONSIBLE FOR PAYMENT:
Name: _____ Social Security #: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone Numbers: _____ _____ _____
Home Mobile Work
Employer: _____ Employer's Address: _____

INSURANCE INFORMATION: (Note: If card is provided, only complete Insured's Name & Insurance Carrier's Name)

PRIMARY Insurance Carrier: _____ ID Number: _____
Insured's Name: _____ Relationship to Patient: Self _____ Spouse _____ Parent _____
Insured's Social Security Number: _____ Date of Birth: _____
Group Name &/or Number: _____ Insurance through Employer? Yes No
Claims Mailing Address: _____
Office Visit Copay: _____

SECONDARY Insurance Carrier (if any): _____ ID Number: _____
Insured's Name: _____ Relationship to Patient: Self _____ Spouse _____ Parent _____
Insured's Social Security Number: _____ Date of Birth: _____
Group Name &/or Number: _____ Insurance through Employer? Yes No
Claims Mailing Address: _____
Office Visit Copay: _____

AUTHORIZATION FOR INSURANCE, RELEASE OF INFORMATION, AND CONSENT
I hereby authorize payment directly to The Natural Health Clinic, or it's designate, for medical benefits payable for services rendered in the course of my treatment. I authorize The Natural Health Clinic, or it's designate, to release my medical information to my insurance carrier or a third party administrator in order to secure settlement of my health insurance claim(s.) I understand that I am fully responsible for prompt payment of all fees remaining after the insurance carrier settlement, if any, of the claim. I understand that if I neglect my personal financial responsibility, my account will be sent for formal collection proceedings, and I will also be responsible for payment of all associated fees for such services.

Responsible party's Signature: _____ Date: _____

Visit us online at www.fstreetnaturalhealthclinic.com and 

NATURAL HEALTH CLINIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Laura Shelton, N.D., Emily Sharpe, N.D., or Kelsi Ervin, N.D..

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. This notice is posted for your review at all times in the Clinic waiting room. You may request a copy for your records if you wish.

By my signature below I acknowledge the availability of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship to patient

This form will be retained in your medical record.

NATURAL HEALTH CLINIC

ADULT HEALTH HISTORY

To help us meet all your healthcare needs, please fill out this form completely. Please use ink. This is a confidential record of your health history.

Today's date _____
Name _____
(Last, First MI)
Date of birth _____ Age _____
Relationship status: Single, Married/Partnered, Separated/Divorced, Widowed/Widower
Spouse/Partner name _____
Do you have children?_____ Age(s)_____
What are your goals for today's visit? Please be specific _____
_____
_____
Are you interested in preventative healthcare? _____
Are there any specific conditions that you are concerned about? _____
_____
_____
When was your last physical exam? _____
Name of Doctor _____
When was your last dental exam? _____
Name of Doctor_____
Please list all allergies (food, drugs, environment) _____
_____
_____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and dates these occurred _____
_____
_____
Please describe all serious accidents, severe injuries, head injuries, broken bones and dates
_____
_____
Please list all prescription and over the counter medications you are currently taking
_____
_____
Please list all nutritional and herbal supplements you are currently taking _____
_____
_____

- Continued on the next page -

Name _____

Usual weight:_____ Happy with weight? _____
How much sleep do you get?_____ From _____p.m. to _____a.m.
How well do you sleep?_____
What is your daily exercise level? - Light - - Medium - - Heavy -
Do you do any exercise for the sake of your health?_____ What?_____
How long at a time?_____
How often?_____ Do you enjoy it?_____
Over the past few years how would you describe your stress level?
- none - - mild - - moderate - - severe -
In regard to the past several months can you say that you:
Enjoy your job/what you do during the day? _____
Enjoy your relationships with people in your life? _____
Are you feeling confident about your ability to cope? _____

Diet:
Are you vegetarian – vegan –avoiding allergens ? _____
What did you eat yesterday?
Breakfast:_____
Snack:_____
Lunch:_____
Snack:_____
Dinner:_____
Snack:_____
Is this typical?_____ If not, what is?_____
_____
_____

Lifestyle:
Smoking (type & amount per day)_____If former smoker, date quit_____
Alcohol (type & amount per week)_____
Caffeine (type & amount per week)_____
Recreational drugs (type & amount per week)_____
Do you always wear a seat belt while in a vehicle?_____
Do you always wear a helmet on a bike or motorcycle?_____
Do you practice safer sex?_____
Have you ever felt threatened by an intimate partner or ex-partner?_____
Do you know of any exposure, past or present, to any of the following:
- mercury - lead - arsenic - zinc - herbicides - pesticides - urea formaldehyde (e.g. from foam insulation or particle board) - other toxic chemicals?_____

- Continued on the next page -

Name _____

Review of Systems:

Do you have now (please put "C" for current), or have you had within the past year (please put "P" for past year):

_____Weakness or paralysis
_____ Joint pain or stiffness
_____ Swollen joints
_____ Muscle cramps/spasms
_____ Tire easily or weakness
_____ Leg cramps
_____ Frequent nosebleeds
_____ Skin trouble or changes
_____ Skin rash
_____ Yellow skin tone
_____ Easy bleeding or bruising
_____ Chest pain or discomfort
_____ Heart palpitations/fluttering
_____ Eye pain or problems
_____ Double/blurred vision
_____ Infected eyes
_____ Wear glasses/contacts
_____ Change in appetite
_____ Difficulty swallowing
_____ Abdominal cramping
_____ Rectal bleeding
_____ Diarrhea
_____ Black tarry stools

_____ Constipation
_____ Hemorrhoids
_____ Ear pain
_____ Ringing in ears
_____ Discharge from ears
_____ Ear infections
_____ Decrease in hearing
_____ Purple/white fingers/lips
_____ Persistent hoarseness
_____ Shortness of breath
_____ Chronic/frequent cough
_____ Sinus infections
_____ Loss of smell
_____ Frequent colds
_____ Sore tongue or gums
_____ Enlarged veins
_____ Sensitivity to heat/cold
_____ Night sweats/hot flashes
_____ Memory loss
_____ Dizziness/fainting
_____ Lack of sex drive
_____ Painful intercourse
_____ Change in nails or hair

_____ Breast lump/discharge
_____ Recent weight changes
_____ Increase in thirst
_____ Vomit/cough up blood
_____ Vomiting
_____ Dark urine
_____ Frequent urination/night
_____ Frequent urination/day
_____ Difficulty starting urine
_____ Painful urination
_____ Leakage of urine
_____ Blood in urine
_____ Seizures
_____ Depression
_____ Sleeplessness
_____ Poor coordination
_____ Persistent fever
_____ Headaches
_____ Migraines
_____ Frequent belching
_____ Heartburn
_____ Nausea
_____ Bloody sputum

Women only:

_____ Age period began
_____ How many days between periods?
_____ Is the flow heavy?
_____ Do you bleed or spot between flows?
_____ Do you have pain or cramps? PMS?

_____ Date of last period
_____ Date of last pelvic
_____ Date of last mammogram
_____ Vaginal itching?
_____ Abnormal pap results?

Men only:

_____ Discharge from penis
_____ Pain/lump in testicles
_____ Impotence

- Please continue on next page -

Name _____

Past Medical History:

Please check spaces for conditions that you have had; leave blank if uncertain

_____Measles	_____Migraine headaches	_____ Hives or Eczema
_____Mumps	_____Tuberculosis	_____AIDS or HIV+
_____Chickenpox	_____Diabetes	_____Infectious Mono
_____Whooping Cough	_____Cancer	_____Bronchitis
_____Scarlet Fever	_____Polio	_____Mitral Valve Prolapse
_____Pneumonia	_____Glaucoma	_____Stroke
_____Rheumatic Fever	_____Hernia	_____ Hepatitis
_____Strep Throat	_____Ulcer	_____Kidney Disease
_____Arthritis	_____Anemia	_____Epilepsy
_____ Ear infection	_____ Sinus infection	_____ Antibiotics
_____Venereal Disease	_____Back trouble	_____Thyroid Disease
_____Heart disease	_____Asthma	_____ Bladder Infections
_____High or low blood pressure		_____Date of last chest x-ray
_____Bleeding tendency		_____Blood or Plasma transfusions

_____Any other disease (please list) _____

Family Medical History:

Please mark if you have any blood relative that has or has had any of the following conditions.

_____High blood pressure	_____Tuberculosis	_____Diabetes
_____Bleeding tendency	_____Heart disease	_____Stroke
_____Drug/alcohol problem	_____Epilepsy	_____Allergies
_____Chronic lung disease	_____Cancer	_____Asthma
_____Mental Illness	_____Leukemia	_____Obesity
_____Migraine headaches	_____Ulcer	_____Depression
_____Thyroid disease	_____Gout	_____Glaucoma
_____High cholesterol	_____Kidney disease	_____Dementia / Alzheimer's

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

X_____ _____

Patient Signature Date