Center for Natural Medicine, Inc.
Medical Health Questionnaire

Last Name: ______________________________ First Name:___________________________ Date of Birth ___/____/____

CENTER FOR NATURAL MEDICINE, INC.
16844 Easy Street, Eagle River, Alaska 99577
Appointments Call: 907-694-5522 - Billing Call: 907-561-9191
EIN 32-0203432

WELCOME TO THE CENTER OF NATURAL MEDICINE, INC

Welcome! We would like to thank you for selecting the Center for Natural Medicine, Inc. to address your health needs. We are dedicated to helping you restore, achieve and maintain your overall health using natural medicine.

Enclosed you will find your Intake Registration Forms including:

- Client information form
- Insurance information form
- Health history questionnaire
- Consent for treatment form
- Privacy practice notification
- PHI communications/restrictions summary

Please fill out these forms in **BLACK INK** prior to your arrival and bring them with you.

If you should have any questions regarding the enclosed forms please call us and we will be happy to help.

Please contact your insurance carrier to see if they cover our services. Knowing your copay and deductible prior to your visit is very helpful.

Completing this paperwork ahead of time will allow us to apply your coverage on your initial visit. Once your insurance has been verified, we require payment of all deductibles and/or co-payments, as defined by your primary carrier.

Because the providers at Center for Natural Medicine, Inc. are very busy, it is absolutely necessary for you to give at least 24 hours notice if an appointment needs to be rescheduled or canceled.

We look forward to meeting and helping you reach your health goals.

Thank you.

Your Health Team,

The Center For Natural Medicine

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CLIENT INFORMATION

Today's Date: _______________________ WORK RELATED VISIT? **YES** **NO**

Client Name: ____ DOB: _________ SSN: ____________

Mailing Address: ____
Street City State Zip

Home Phone: ________________________________ Work Phone: ______________________________

Parent/Legal Guardian (if different from client): ____
(person responsible for bill if patient is under 18)

Emergency Contact: _____________________Phone: _______________ Relationship: ____________

Responsible Party Employer: ____

Referral Source: ____

Method of Payment Today: ___ Cash/Check ___ Credit Card ___ Money Order

Cancellation Policy: ***There is a fee charged for appointments not cancelled 24 hours prior to the scheduled appointment which is 50% of the scheduled visit charge.***

CLIENT PAYMENT AGREEMENT

I understand that I am responsible for any charges NOT COVERED AND PAID by my insurance company or other third party resources.

ASSIGNMENT OF INSURANCE/BENEFITS: **By signing below, I authorize THE CENTER FOR NATURAL MEDICINE to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. This authorization shall be valid only for the period of time necessary to actually process payment claim pertaining to the client but in any case shall cease to be valid one (1) year from this date.**

THIS FACILITY IS NOT ENROLLED IN FEDERAL OR STATE PROGRAMS, AND THEREFORE DOES NOT ACCEPT ASSIGNMENT OF BENEFITS FOR FINANCIAL PROGRAMS OF THIS NATURE.

SIGNATURE:____DATE: ______________________

WITNESS:____DATE:_______________________

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INSURANCE INFORMATION

Primary Insurance Company Name: ____

Claim Office Address: ____

Claim Office Phone #: ____

Subscriber Name: _______________________________ DOB: __________________________________

Policy/Group Number: ____________________________ SSN: __________________________________

Secondary Insurance Company Name: ____

Claim Office Address: ____

Claim Office Phone #: ____

Subscriber Name: _______________________________ DOB: __________________________________

Liability Insurance Company Name: ____

Claim Office Address: ____

Claim Office Phone #: ____________________________ Date of Injury: ____________________________

Insured's Name: _______________________________ Policy #: _________________________________

Name of Adjustor: ________________________________ SSN: __________________________________

Work Comp Insurance Name: ____

Claim Office Address: ____

Claim Office Phone #: ____________________________ Date of Injury: ____________________________

Name of Adjustor: _______________________________ Claim #: ________________________________

Name of employer at time of injury: _______________________________ Contact person: ______________

Is this claim in dispute? YES NO Are you being represented by legal council? YES NO

Name of Attorney: ____

Address: ____ Phone: ___________________________

SIGNATURE:____DATE: ______________________

WITNESS:____DATE:______________________

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PATIENT PROFILE

Please list the most important reason you came in today:____

____

What other health concerns do you have at this time:____

____

Have you ever consulted with a Naturopathic physician or Acupuncturist before? □Yes □No
How did you hear about us?
□ Friend/Patient □ Referral □ Walk in
□ Website □ Social Media □ Physician/Specialist
In general, would you say your health today is: □ Excellent □Very Good □ Good □ Fair □ Poor

MEDICAL CARE
Please list other providers/specialists involved in your care and their clinic phone number:

Name of Provider/Specialist	Phone Number	Reason for Visit

HEALTH HABITS

Do you drink alcoholic beverages? □ Yes □ No If yes, how many drinks per day?_________
Current or past tobacco use: Amount/pack per day:_____ How long:_____ Quit date:_____ Do you want to quit:___
Do/did you use: □ Caffeine □ NutraSweet □ Margarine □ Marijuana □ Chewing tobacco □ Diet pills
Hobbies:____
Do you exercise regularly? □ Yes □ No If yes, please describe type of exercise and how often:
____
Sleep: How many hours?_____ □Light □ Sound □ Insomnia
Current weight:______ Current height:_____ Target weight:_____ Last time you weighed yourself:______________
Have you had recent unexplained weight gain? □Yes □No
Have you had recent unexplained weight loss: □Yes □No

DIET
□ Standard American (meat, potatoes, dessert) □ Wholesome □ Vegan □ Vegetarian □ Fast food
What do you typically eat:

Breakfast:____

Lunch:____

Dinner:____

What do you typically drink during the day:____

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REVIEW OF SYSTEMS

Mark all symptoms that you have experienced within the PAST 6 MONTHS (approximately). Mark all that apply – if no symptoms, please mark "none".

GENERAL SYMPTOMS

□ Lack of energy
□ Inability to exercise
□ Excessive fatigue
□ Weight loss
□ Weight gain
□ Loss of appetite
□ Chills or fevers
□ Night sweats
□ Trouble sleeping
□ NONE

SKIN

□ Rash
□ Itching
□ Dry skin
□ Changing mole or skin spot
□ Yellowing of the skin (jaundice)
□ Poor healing of skin wounds
□ NONE

EYES

□ Loss of vision
□ Marked decrease in vision
□ Double vision
□ Eye pain
□ NONE

EAR, NOSE AND THROAT

□ Difficulty hearing
□ Ringing in ears
□ Sore throat
□ Hoarseness
□ Difficulty speaking
□ Nosebleeds
□ Sinus congestion/infection
□ NONE

RESPIRATORY

□ Cough
□ Coughing up blood
□ Coughing up phlegm
□ Wheezing
□ pain with breathing
□ Exposure to lung irritants
□ Snoring
□ Daytime sleepiness
□ Stopping breathing when asleep
□ NONE

CARDIOVASCULAR

□ Chest pain
□ Chest pressure or discomfort
□ Jaw or arm pain with exertion
□ Skipping beats or pauses
□ Heart fluttering or palpitations
□ Racing heartbeat
□ Very slow heartbeat
□ Fainting or nearly fainting
□ Lightheadedness with standing
□ Shortness of breath with exertion
□ Shortness of breath lying down
□ Waking up at night short of breath
□ Swelling of ankles or legs
□ Pain in legs with walking
□ NONE

GASTROINTESTINAL

□ Difficulty swallowing
□ Acid reflux or heartburn
□ Nausea
□ Vomiting
□ Indigestion
□ Pain with or after eating meals
□ Abdominal pain
□ Change in bowel habits
□ Diarrhea
□ Blood in stools
□ Black or maroon bowel movements
□ NONE

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REVIEW OF SYSTEMS CONT…

GENITOURINARY

□ Urinating frequently
□ Urinary urgency
□ Incontinence
□ Trouble starting urine stream
□ Frequent nighttime urination
□ Unable to empty bladder
□ Blood in urine
□ Frequent urinary infections
□ Possibly or definitely pregnant
□ Missed periods
□ Excessively heavy periods
□ On hormones or birth control
□ NONE

MUSCULOSKELETAL

□ Joint pain
□ Joint swelling
□ Stiffness in joints
□ Muscle pain/aches
□ Muscle weakness
□ Muscle cramps
□ Back pain
□ Neck pain
□ Pain down legs or arms
□ NONE

NEUROLOGICAL

□ Headaches
□ Migraine headaches
□ Dizziness or vertigo
□ Tremors
□ Numbness or tingling
□ Poor balance
□ Failing down or stumbling
□ Poor coordination
□ Memory loss
□ Poor concentration
□ Weakness on one side
□ Garbled or inappropriate speech
□ NONE

PSYCHIATRIC

□ Crying or sadness
□ Feeling depressed
□ Thoughts of suicide
□ Panic Attacks
□ Anxiety spells
□ Mood swings
□ NONE

ENDOCRINE

□ Excessive thirst
□ Excessive eating
□ Excessive urination
□ Intolerance to cold
□ Intolerance to heat
□ Excessive sweating
□ pain or swelling at front of neck
□ High cholesterol
□ NONE

HEMATOLOGICAL/ONCOLOGICAL

□ Easy bruising
□ Excessive bleeding
□ Excessive/inappropriate clotting
□ pain or swelling in back of calf
□ Enlarged lymph nodes
□ Recent diagnosis/recurrence of cancer
□ NONE

ALLERGIC/IMMUNOLOGICAL INFECTIONS

□ Frequent infections
□ Persistent infections
□ Exposure to HIV/AIDS
□ Exposure to hepatitis
□ Using steroids or immune suppressing drugs
□ Seasonal allergies
□ Food allergies
□ NONE

Do you have OTHER SYMPTOMS not listed?

□ Yes
Explain:____
□ No

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MEDICAL HISTORY

Please check box to indicate if you or a family member has ever had the following conditions. Please indicate which relative has the condition (MGM = maternal grandmother; MGF – maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather).

Condition	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF
Allergies								
Anemia								
Anxiety								
Asthma								
Blood Transfusion								
Cancer								
Cataracts								
Congestive heart failure								
Clotting disorder								
COPD								
Depression								
Diabetes								
Ear Infections								
Eczema								
Emphysema								
Frequent Colds								
Frequent Headaches								
Gallstones								
GERD								
Glaucoma								
Gout								
Heart Attack								
Heart Murmur								
Hemorrhoids								
Herpes								
Hypertension								
Irritable Bowel Syndrome								
Kidney Disease								
Meningitis								
Migraines								
Mononucleosis								
Nerve/muscle disease								
Neurosis/psychosis								
Osteoporosis								
Parkinson's/Alzheimer's								
Psoriasis								
Seizures								
Sickle Cell Anemia								
STDs								
Stroke								
Substance Abuse								
Thyroid Disease								
Trauma, major								
Tuberculosis								
Ulcers								

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ALLERGIES

Please indicate allergy and reaction?

Type	Name	Reaction
Medication		
Food		
Environmental		

□ No known drug allergies

MEDICATION

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if necessary.

Name of medication/supplement (such as Synthroid, Vitamin D, etc.)	Strength (88mcg, etc)	Directions (such as 1 tablet twice a day, as needed, etc)
□ Check if none		

SURGICAL HISTORY

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization Date:

____ ________/________/________

____ ________/________/________

____ ________/________/________

____ ________/________/________

____ ________/________/________

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MEDICAL CARE

Where did you last receive medical care?____

For what reason?____

Date of last physical exam:	Date of last lab work:
Date of last EKG:	Date of last tetanus shot:
Date of last TB test:	Date of last chest x-ray:
Date of last rectal exam:	

Men:

Date of last prostate exam:	Have you had a vasectomy? □ Yes □ No

Women:

Age of first period:	First day of last normal period:	Number of pregnancies:
Number of live births:	Number of children living with you	Birth control method
Date of last pap	Done where	
Date of last mammography	Done where	
Date of last bone densitometry (dexa)		

____ _____/_____/_____

Patient Signature **Date**

____ _____/_____/_____

Provider Signature **Date**

Thank you for taking the time to provide this information so that we may provide you with more effective care.

Last Name: ______________________________ First Name:___________________________ Date of Birth ___/____/____

CONSENT FOR TREATMENT

General Information: Due to the diversity of modalities offered at the Center for Natural Medicine, Inc., your treatment may include any or all of the following general modalities: Acupuncture and Oriental Medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: Insertion of special sterilized needles at specific points on the body. **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.

Acupressure: Traditional Chinese medical massage and manual therapy.

Infrared Heat: Applying heat generated by an infrared lamp over a specific area of the body.

Dermal-friction Technique: Friction is applied topically to the skin using a smooth object to relieve symptoms.

Cupping: Glass cups are placed on the skin with a vacuum created by heat or suction device.

Dietary Advice: Suggestions for nutrition and herbal food products.
Liniments, Oils, Plasters: Herbal formulas applied topically to the skin.

Moxa: A soft woolly mass prepared from ground young leaves, typically in the form of sticks or cones which are ignited and placed on or close to the skin or used to heat acupuncture needles.

Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections).

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Minor Surgery and IV Therapies: As deemed appropriate by clinicians.

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Potential Risks These include, but are not limited to: pain, discomfort, blistering, bruising, discolorations, infection, burns, dizziness, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; broken needle; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms., possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax).

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment

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, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Center for Natural Medicine, Inc., or any of its personnel regarding cure or improvement of my condition. I hereby release Center for Natural Medicine, Inc. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. 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 my representative or me or otherwise permitted or required by law.

____	____
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
____	____
Guardian/Personal Representative's Signature	Patient's Signature
____	________________________
Relationship/Representative's Authority	Date

Date

Last Name: _____________________________ First Name:__________________________ Date of Birth ___/____/____

NOTICE OF PRIVACY PRACTICES

I consent to the use of disclosure of my identifiable health information by the Center for Natural Medicine, for the purpose of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at Center for Natural Medicine may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Acupuncturist, Massage Therapist or other health care worker employed by or under contract with the Center for Natural Medicine.

Patient means any person seeking health care advice and/or treatment of a practitioner at the Center for Natural Medicine, through consultation by phone or in person.

My *identifiable health information* means information collected from me and created or received by my practitioner, another health care provider, a health plan, any my employer. This *identifiable health information* results to my past, present, or future, physical or mental health condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that I have the right to request a restriction as to how my health care information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Center for Natural Medicine is not required to agree to the restrictions that I may request. However, if the Center for Natural Medicine agrees to a restriction that I request, the restriction is binding on the Center for Natural Medicine.

I have the right to revoke this consent, in writing, at any time except to the extent the Center for Natural Medicine has taken action in reliance of the consent.

I understand that I have the right to review the Center for Natural Medicine, Inc. Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operation of Center for Natural Medicine, Inc.

Center for Natural Medicine, Inc. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________________________

Patient's Name (PRINT) Guardian/Personal Representative's Name (PRINT)

_________________________________ ____

Patient's Signature Guardian/Personal Representative's Signature

_________________________________ ____

Date Relationship/Representative's Authority

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PHI COMMUNICATION/RESTRICTION SUMMARY

SUMMARY OF PHI COMMUNICATION & PHI INSTRUCTIONS

I, ____, the above referenced patient or the guarantor for the above referenced patient request the following guidelines regarding the release of confidential medical information.

ORAL COMMUNICATIONS are limited to:

☐ Home (   ) __________.

☐ Work (   ) __________.

☐ Cell (   ) __________.

☐ Other (   ) __________.

May we leave a message? Yes No

May we leave a number to call back? Yes No

May we leave an appointment reminder? Yes No

WRITTEN COMMUNICATIONS (EMAIL) are limited to:

☐ Home____

☐ Work____

☐ Other____

PHI AUTHORIZATIONS are limited to:

Account or appointment information may be released to the following person(s):

☐_________________________________Relationship____________Phone___________

☐_________________________________Relationship____________Phone___________

☐_________________________________Relationship____________Phone___________

*These instructions will expire 1 year from date signed or when revoked in writing by the patient.

SIGNATURE:____DATE:_________

WITNESS:____DATE:_________