Orchard Holistic Medicine
205 Bethel Ave, Port Orchard WA 98366
360-602-2806

Personal Information

Date ______________________________

Name ______________________________

Address ______________________________

City ______________ State _____ Zip __________

Occupation ______________________________

☐ Home Phone ______________________________

☐ Work Phone ______________________________

☐ Cell Phone ______________________________

Mark the box next to contact number above that is the best way to reach you and is okay to leave a message.

Birth Date ______________ Age __________

Email Address ______________________________

☐ Married/Partnered ☐ Single

Your Partner (first contact in case of emergency)

Name ______________________________

Occupation ______________________________

Employer ______________________________

Business Address ______________________________

Business Phone ______________________________

Cell Phone ______________________________

Getting To Know You

Is another family member/relative a patient here? ☐ Yes ☐ No

Name ______________________________

Referred by:

☐ Internet Search/Our Website ☐ Yellow Pages ☐ Sign

☐ Insurance Provider ______________________________

☐ Family Member ______________________________

☐ Friend ______________________________

☐ Other (Explain) ______________________________

Insurance

Primary Carrier ______________________________

Insured's Name ______________________________

Employer ______________________________

Group # ______________________________

ID # ______________________________

Secondary Carrier ______________________________

Insured's Name ______________________________

Employer ______________________________

Group # ______________________________

ID # ______________________________

Account Information

Name of Person Responsible for Account:

____

Social Security # ______________________________

Occupation ______________________________

Employer ______________________________

Business Address ______________________________

City ______________ State _____ Zip __________

Business Phone ______________________________

Closest Relative Not Living With You:

Name ______________________________

Relation ______________________________

Address ______________________________

City ______________ State _____ Zip __________

Phone ______________________________

Additional Person To Contact In Case Of Emergency (if partner listed above is not available):

Name ______________________________ Relationship ______________

Home Phone ______________ Cell ______________ Work ______________

Address ______________________________

City ______________________________ State _____ Zip __________

Financial Policy

Payment: As a patient of this office you are directly responsible for payment of all charges incurred while under treatment unless you are eligible for insurance reimbursement with an insurance carrier the doctors have contracted with. Payments are due when services are rendered, supplies are received, or laboratory tests are ordered. If the doctor is contracted with your insurance carrier, all deductibles, co-pays and balances that are the patient's responsibility are due at the time of service. Accepted methods of payments are: personal checks, debit and credit Visa and Master cards, and cash.

Insurance: If the doctor is contracted with your insurance carrier we will bill your insurance directly. We will make every effort to determine benefits and eligibility prior to treatment. What we are told by your insurance carrier will govern how we determine your liability. We are not responsible for payment discrepancies that might occur once the reimbursement check is received. It is the patient's responsibility to keep tract of their deductible, maximum benefit, or other liabilities specific to their plan's coverage. If you are not covered by one of our contracted carriers and think that your insurance will cover naturopathic care, at your request we will provide you with an insurance billing form that you can submit to receive payment from your insurance company. (Weight Loss Programs are not covered by insurance.)

Senior Discount: A 10% discount on service (out-source lab, medications received from our dispensary and weight loss programs are not included) will be given to our patients who are age 65 or over. Due to State and Federal regulations, we cannot process medical coupons and Medicare/Medicaid claims.

Cancellations: Please give us at least 24 hours advance notice of your inability to keep an appointment. If less than 24 hours notice is received the amount of the scheduled visit will be charged (except in emergencies).

Late Fee: Accounts over ninety (90) days outstanding are overdue and may be acted on for collection. Collection costs are added to your account. A late fee of $1.50 or 1.0% of the balance per month, whichever is greater, is charged on overdue accounts. There is a $10.00 charge for returned checks and payment is due in the amount of the check plus the returned check fee within ten (10) working days.

Authorization for Treatment

I, the undersigned, hereby acknowledge that the care being provided at Orchard Holistic Medicine is designed to improve my health or condition. I authorize the doctor to perform diagnostic tests deemed necessary for my care, to perform any and all forms of treatment, to include medication, and therapy that are indicated and that I am in agreement with and are in accordance with the Standards of Naturopathic Care. If procedures are performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. I understand that every effort will be made by the office to fully disclose information about the procedures used. If I have questions about these procedures I will ask them until they are answered to my full satisfaction. I further acknowledge that there is no guarantee or warrantee, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.

If while under the doctor's care I experience a medical emergency, I am to dial 911. If I have a medical concern I am to phone the office to report. If my concern occurs during after hours I will phone the office where instructions on how to contact the doctor can be obtained on the after hours message prompts.

I understand and agree to the above ***Financial Policy*** and ***Authorization for Treatment***. I will abide by its terms.

______________________________ ______________

Signature of Patient or Responsible Party Date

______________________________ ______________________________

Patient (print) Responsible Party/relationship to patient (print)

______________________________ ______________

Witness Date

Name ______________________________ Age ____ Birth Date __________ ❏ F ❏ M Blood Type ________________

# of Children _______ Names & Ages ____

List Your Current Health Problems

Prioritize by listing the problems in order of importance.

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

Complete the following section for your top 3 problems (Check the bold descriptors that apply):

Problem #1: ____ Date of Onset: ______________

Describe: ____

Cause: ____ ❏ **Constant?** or ❏ **Intermittent?**

❏ **Worsening** or ❏ **Improving?** Why? ____

Rx / Surgery / Treatments tried & the results: ______________________________________

Associated personal and/or family history: ____

How does problem #1 effect your body / your life?: __________________________________

Office Use Only ____

Problem #2: ____ Date of Onset: ______________

Describe: ____

Cause: ____ ❏ **Constant?** or ❏ **Intermittent?**

❏ **Worsening** or ❏ **Improving?** Why? ____

Rx / Surgery / Treatments tried & the results: ______________________________________

Associated personal and/or family history: ____

How does problem #2 effect your body / your life?: __________________________________

Office Use Only ____

Review Date/Sig: ______________

Problem #3: ____ Date of Onset: _______________

Describe: ____

____

Cause: ______________________________________ ❑ **Constant?** or ❑ **Intermittent?**

❑ **Worsening** or ❑ **Improving?** Why? ______________________________________

____

Rx / Surgery / Treatments tried & the results: ______________________________________

____

Associated personal and/or family history: ______________________________________

____

How does problem #3 effect your body / your life?: ______________________________________

____

Office Use Only ____

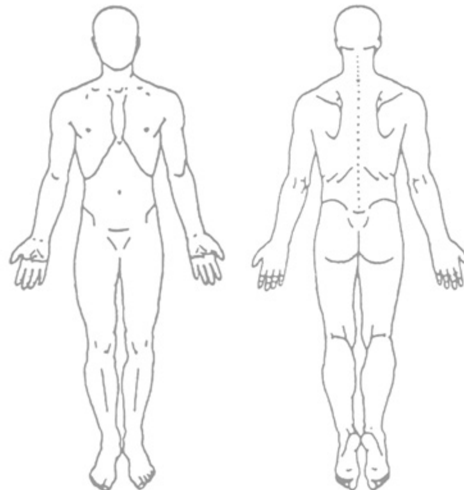
____

____

Use diagram to illustrate the areas on your body where you feel any of the following sensations:

Use the following letters to mark the diagram:

A = Numbness
B = Deep Aching
C = Burning
D = Stabbing
E = Pins & Needles
F = Throbbing
G = Itching



General Information

Have you seen a naturopathic doctor before? ❑ No ❑ Yes

Are you currently seeing one? ❑ No ❑ Yes Doctor's name: ______________________________

Do you have a medical doctor? ❑ No ❑ Yes Doctor's name: ______________________________

Have you seen a chiropractic doctor before? ❑ No ❑ Yes

Are you currently seeing one? ❑ No ❑ Yes Doctor's name: ______________________________

Do you see any other healthcare professional (i.e. acupuncturist, massage therapist, counselor)? ❑ No ❑ Yes

Explain: ____

What are the most significant measures that you have taken to improve your state of health? ______________________

____

____

Tobacco Use: ❑ No ❑ Yes Smoke/Chew: _________ years – Amount Per Day: ____________ Year Stopped: ____________

Alcohol Use: ❑ No ❑ Yes Type: ______________________________ Frequency: ____________________

Recreational Drug Use: ❑ No ❑ Yes Type: _________________________ Frequency: ____________________

Review Date/Sig: _________________

Your Medical History

List the prescription and non-prescription medications, vitamins, minerals, & herbs that you are currently taking:

____

____

List any medications that have been prescribed, but you are not taking: ______________________

List major illnesses, hospitalizations surgeries or serious injuries (include date & brief description): ______________________

____

Allergies to drugs, food, or other substances? ❏ No ❏ Yes Describe: ______________________

Height __________ Weight __________ Weight 1 year ago __________ Max Weight __________ When __________

Minimum Adult Weight __________ When __________ Blood Pressure __________ Heart Rate __________

Personal | Family History (❏ Unknown)

Please check and name who was affected (Self, Mother, Father, Grandparents, Sisters, Brothers, Children)

❏ AIDS/HIV __________
❏ Alcoholism __________
❏ Allergies __________
❏ Anemia __________
❏ Arthritis __________
❏ Asthma __________
❏ Cancer __________
❏ Depression __________
❏ Diabetes __________
❏ Drug Problems __________
❏ Eczema __________
❏ Gout __________
❏ Heart disease __________
❏ High blood pressure __________
____
❏ Hypoglycemia __________
❏ Kidney disorder __________
❏ Mental illness __________
❏ Migraines __________
❏ Obesity __________
❏ Psoriasis __________
❏ Senility __________
❏ Sex abuse __________
❏ Seizures __________
❏ Stroke __________
❏ Suicide __________
❏ TB __________
❏ Thyroid problems __________
❏ Ulcer __________
❏ Other __________

Review of Systems

Please check all the problems you have currently (in the past week):

Constitutional
- Good general health ❏
- Recent weight change ❏
- Night sweats, fevers ❏
- Fatigue/weakness ❏

Ears / Nose / Mouth / Throat
- Hearing loss or ringing ❏
- Sinus problems ❏
- Nose bleeds ❏
- Sore throat/voice change ❏

Eyes
- Wear glasses/contacts ❏
- Blurred/double vision ❏
- Eye disease or injury ❏
- Eye pain/dryness ❏

Cardiovascular
- Chest pain ❏
- Palpitations ❏
- Heart trouble ❏
- Swelling hands/feet ❏
- Lightheaded ❏

Respiratory
- Shortness of breath ❏
- Cough ❏
- Wheezing/Asthma ❏
- Coughing up blood ❏

Gastrointestinal
- Nausea/vomiting ❏
- Abdominal pain ❏
- Rectal bleeding ❏
- Indigestion/heartburn/reflux ❏
- Constipation/diarrhea ❏

Musculoskeletal
- Muscle pain or cramps ❏
- Stiffness/swelling joints ❏
- Joint pain ❏
- Trouble walking ❏

Neurological
- Frequent headaches ❏
- Paralysis or tremors ❏
- Convulsions/seizures ❏
- Numbness/tingling ❏

Hematologic / Lymphatic
- Anemia ❏
- Bruise easily ❏
- Slow to heal ❏
- Enlarged glands ❏

Endocrine
- Excessive thirst/urination ❏
- Hair loss ❏
- Cold hands and feet ❏
- Hormone problems ❏
- Light sensitivity ❏

Integumentary/Skin
- Abnormal nails ❏
- Rashes or itching ❏
- Breast irregularity ❏
- Dry/discolored Skin ❏

Allergic / Immunologic
- Food allergies ❏
- Frequent infections ❏
- Hay fever ❏
- Chemical Sensitivity ❏

Genitourinary
- Blood in urine ❏
- Pain/burning on urination ❏
- Frequent urination ❏
- Kidney stones ❏

Genitourinary – Continued
- Sexual problems ❏
- Testicle/ovary pain ❏
- Infertility ❏
- Menstrual problems ❏

Psychiatric
- Insomnia ❏
- Confusion/memory loss ❏
- Depression ❏
- Anxiety/panic attacks ❏

Review Date/Sig: ______________

Name: ______________________________ Date of Birth: ______________

Menstrual/Reproductive History

Menses

Age period began? ______________ Date of last period: ______________

Regular periods? ❑ No ❑ Sometimes ❑ Yes

Periods every days _____________ (length of time between the start of one period to the start of the next)

Flow: ❑ Heavy ❑ Medium ❑ Light Duration: _____________ days

Spotting? ❑ No ❑ Yes Midcycle: ❑ No ❑ Yes Instead of period ❑ No ❑ Yes

Bloating? ❑ No ❑ Yes Cyclical premenstrual weight gain: ❑ No ❑ Yes How much? ______ lbs.

Cramps? ❑ No ❑ Yes Duration: _____________ days Intensity: ❑ Mild ❑ Moderate ❑ Severe

PMS? ❑ No ❑ Yes Describe: ______________________________

Pregnancy

Currently pregnant? ❑ No ❑ Yes Planning? ❑ No ❑ Yes When: ______________________________

Prior Pregnancies: # ______ Births: # ______ Miscarriages: # ______ Abortions: # ______ C-sections: # ______

Complications? ❑ No ❑ Yes Describe: ______________________________

Type of birth control: ______________________________

Ever use birth control pills? ❑ No ❑ Yes How long/When? ______________________________

Hormones

Menopausal? ❑ No ❑ Yes Ovaries present? ❑ No ❑ Yes Uterus present? ❑ No ❑ Yes

Date Uterus or Ovaries were removed: ______________________________

Hot flashes? ❑ No ❑ Yes Rx: ______________________________ Onset: ______________________________

Frequency: ______ times per day/week for ______ minutes. Intensity: ❑ Mild ❑ Moderate ❑ Severe

Painful intercourse? ❑ No ❑ Yes Vaginal dryness? ❑ No ❑ Yes

Breast Exam

Breast pain/lumps? ❑ No ❑ Yes Breast discharge? ❑ No ❑ Yes

Date of last mammogram: _____________ Results: ______________________________

Do you do monthly self-breast exam? ❑ No ❑ Yes If not monthly, how often?: ______________________________

Pelvic Exam

Date of last pelvic exam _____________ Reason: ______________________________

Date of last PAP _____________ Results: ______________________________

Previously abnormal PAP? ❑ No ❑ Yes Date _____________ Results _____________ Therapy _________________

Recurring vaginal yeast infections? ❑ No ❑ Yes Onset: _____________ Frequency: ______________________

Is there anything else you would like the Doctor to know?

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____

____