Kimberly Iller, ND, LAc
Functional Medicine Northwest

8010 15th Ave NW, Suite D; Seattle, WA 98117
Office: (206) 268-0397 FAX: 206-518-9225

Thank you for choosing my clinic! In order to serve you properly, we need the following information. All information is confidential.

**We require proof of identification for patient and if applicable patient guardian. For minors the permission to treat patient is required from both parents. Consent for treatment, below, must be signed by both parents. Guardians please provide official proof of guardianship.

In the event we need to assist you with insurance issues, please provide us with an insurance card and a prescription drug plan card, if applicable. Thank you

Office Use Only
Patient ____________________________Parent/Guardian____________________________
Identification provided

Authorization for Treatment of Minors

I authorize treatment by the providers of Functional Medicine Northwest / Dr. Kimberly Iller, ND LAc for my child or the minor under my guardianship. I am legally entitled to do so and have provided identification for said child and myself. I have also provided proof of guardianship if applicable. ______________________________________
Signature Date
____
Signature Date

Demographics

Date______________ Patient Name (first, last, MI) ______________________________

Soc. Sec # ____________________ Male___ Female___ Birth date _________________

Phone: (____)______________ Cell: (____)____________ Email:__________________

Address:__________________________ City/Zip: ____________________ State:____
CNTRY_______

Do you reside in the United States ( ) yes ( ) no ( ) Part time CNTRY: ______________

Check appropriate box: ( )Minor ( )Single ( )Married ( ) Partnered ( )Divorced ( ) Widowed ( ) Separated Other:

Responsible Party (if not patient)

Minor Parent or Guardian('s) ____

Guardian Circumstance ( )Parent ( )Foster Parent ( )Other _______________________

Parent or Guardian Employer: ________________________ Work Ph: (____)_________

Phone: (____)____________ Cell: (____)___________ Email: _____________________

Address:__________________________ City/Zip: __________________State:_____
CNTRY_________

Primary Care Physician

If you would like us to forward your records to your primary care physician, please request this at each visit and provide us with the FAX number.

Name ______________________________________ ( )M.D. ( )N.D. ( )Other

Phone: (____)________________ FAX: (____)_________________

Address:_________________________ City/Zip:____________ State:___ CNTRY_______

Release of Information

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Health History

Drug allergies: ____

____

Please state your **main health concern:**____

____

____

Describe your **diet:** ____

____

Height:________ Weight: _______ Are you concerned about your weight _______________

Smoking: ( )Yes ( )No __ # per day ___# of years __Years Quit _Pipe _Cigar _Chew

Alcohol Use: ( )Never ( )Daily ( )Weekly Other _________________________________

Exercise: ( )Never ( )Daily ( )Weekly Other ____________________________________

Caffeine: ( )Never ( )Occasional ( )Daily ___# of servings ( )Coffee ( )Pop ( ) ____

Chemical/Occupational Exposures: ( )Asbestos ( )Amalgam fillings How Many _____

Other: ____

Food Sensitivities: ____

Environmental Sensitivities:____

Drugs: (Please check all of the following that apply)

Allergy Medications	Blood Pressure Med	Estrogen Hormone	Nasal Sprays
Thyroid	Antacids	Blood Thinners	Heart Medication
Nitroglycerine	Tranquilizers	Anti Depressant	Cortisone
Insulin	Shots_________	Water Pill (diuretic)	Antibiotics
Decongestant	Laxative	Sleeping Pills	Weight Loss
Asthma Medicine	Diabetes Med.	Marijuana	Steroids
Vitamins	Birth Control	Digitalis	Mood Stabilizer

Family History: Check all of the following in your immediate family (parents, siblings, children)

Alcoholism	Diabetes	High Blood Pressure	Parkinson's	Thyroid
Cancer	Heart Disease	Multiple Sclerosis	Stroke	

Dates Of Last Exams:

Physical Exam ____________

Eye Exam ____________

Dental Exam ____________

Chest X-Ray ____________

Electrocardiogram __________

Men Only: ( ) Discharge from Penis ( ) Prostrate Trouble ( ) Stream Weak or Slow ( ) Swelling or Pain in Testes ( ) Date of Vasectomy

Women Only:

Age menstruation began ___________ Last menstrual period date _________

Menstruation __ Irregular __ Regular __ Painful __ Heavy __ Light ( ) Yes ( ) No Is there any recent change?

Number of pregnancies: ____________ Number of births: ______________

Type of birth control: _________________ How long:___________________

IUD ( ) Yes ( ) No Years inserted: ____ Date of last mammogram:______
History of breast disease: ____