

Orchard Holistic Medicine
210 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 track 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 warranty, 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

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 _____

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: _____

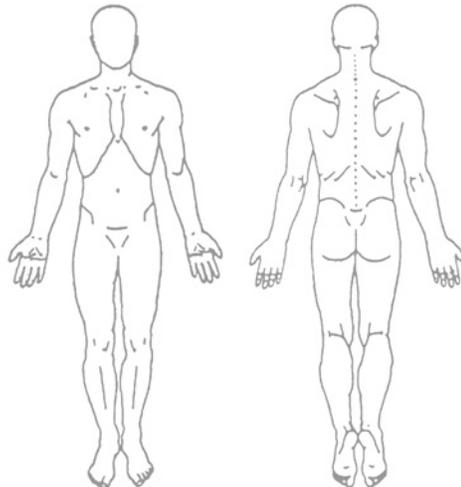
How does problem #3 effect your body / your life?: _____

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: _____

Orchard Holistic Medicine 210 Bethel Ave, Port Orchard, WA 98366 - 360-602-2806 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)

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV _____ | <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Senility _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Sex abuse _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Arthritis _____ | _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney disorder _____ | <input type="checkbox"/> TB _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Mental illness _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Drug Problems _____ | <input type="checkbox"/> Obesity _____ | <input type="checkbox"/> Other _____ |

Review of Systems

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

<p>Constitutional</p> <p>Good general health <input type="checkbox"/></p> <p>Recent weight change <input type="checkbox"/></p> <p>Night sweats, fevers <input type="checkbox"/></p> <p>Fatigue/weakness <input type="checkbox"/></p>	<p>Ears / Nose / Mouth / Throat</p> <p>Hearing loss or ringing <input type="checkbox"/></p> <p>Sinus problems <input type="checkbox"/></p> <p>Nose bleeds <input type="checkbox"/></p> <p>Sore throat/voice change <input type="checkbox"/></p>	<p>Eyes</p> <p>Wear glasses/contacts <input type="checkbox"/></p> <p>Blurred/double vision <input type="checkbox"/></p> <p>Eye disease or injury <input type="checkbox"/></p> <p>Eye pain/dryness <input type="checkbox"/></p>
<p>Cardiovascular</p> <p>Chest pain <input type="checkbox"/></p> <p>Palpitations <input type="checkbox"/></p> <p>Heart trouble <input type="checkbox"/></p> <p>Swelling hands/feet <input type="checkbox"/></p> <p>Lightheaded <input type="checkbox"/></p>	<p>Respiratory</p> <p>Shortness of breath <input type="checkbox"/></p> <p>Cough <input type="checkbox"/></p> <p>Wheezing/Asthma <input type="checkbox"/></p> <p>Coughing up blood <input type="checkbox"/></p>	<p>Gastrointestinal</p> <p>Nausea/vomiting <input type="checkbox"/></p> <p>Abdominal pain <input type="checkbox"/></p> <p>Rectal bleeding <input type="checkbox"/></p> <p>Indigestion/heartburn/reflux <input type="checkbox"/></p> <p>Constipation/diarrhea <input type="checkbox"/></p>
<p>Musculoskeletal</p> <p>Muscle pain or cramps <input type="checkbox"/></p> <p>Stiffness/swelling joints <input type="checkbox"/></p> <p>Joint pain <input type="checkbox"/></p> <p>Trouble walking <input type="checkbox"/></p>	<p>Neurological</p> <p>Frequent headaches <input type="checkbox"/></p> <p>Paralysis or tremors <input type="checkbox"/></p> <p>Convulsions/seizures <input type="checkbox"/></p> <p>Numbness/tingling <input type="checkbox"/></p>	<p>Hematologic / Lymphatic</p> <p>Anemia <input type="checkbox"/></p> <p>Bruise easily <input type="checkbox"/></p> <p>Slow to heal <input type="checkbox"/></p> <p>Enlarged glands <input type="checkbox"/></p>
<p>Endocrine</p> <p>Excessive thirst/urination <input type="checkbox"/></p> <p>Hair loss <input type="checkbox"/></p> <p>Cold hands and feet <input type="checkbox"/></p> <p>Hormone problems <input type="checkbox"/></p> <p>Light sensitivity <input type="checkbox"/></p>	<p>Integumentary/Skin</p> <p>Abnormal nails <input type="checkbox"/></p> <p>Rashes or itching <input type="checkbox"/></p> <p>Breast irregularity <input type="checkbox"/></p> <p>Dry/discolored Skin <input type="checkbox"/></p>	<p>Allergic / Immunologic</p> <p>Food allergies <input type="checkbox"/></p> <p>Frequent infections <input type="checkbox"/></p> <p>Hay fever <input type="checkbox"/></p> <p>Chemical Sensitivity <input type="checkbox"/></p>
<p>Genitourinary</p> <p>Blood in urine <input type="checkbox"/></p> <p>Pain/burning on urination <input type="checkbox"/></p> <p>Frequent urination <input type="checkbox"/></p> <p>Kidney stones <input type="checkbox"/></p>	<p>Genitourinary – Continued</p> <p>Sexual problems <input type="checkbox"/></p> <p>Testicle/ovary pain <input type="checkbox"/></p> <p>Infertility <input type="checkbox"/></p> <p>Menstrual problems <input type="checkbox"/></p>	<p>Psychiatric</p> <p>Insomnia <input type="checkbox"/></p> <p>Confusion/memory loss <input type="checkbox"/></p> <p>Depression <input type="checkbox"/></p> <p>Anxiety/panic attacks <input type="checkbox"/></p>

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?
