NATURAL HEALTH CLINIC
Laura A. Shelton, N.D.
Emily Sharpe, N.D.
1707 F St., 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) are 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 call.**

Office visits will be charged based on the actual time spent with the Doctor, and according to allowable standard insurance rates.

Acute care If you have sudden onset symptoms of ear infection, mastitis, or urinary tract infection, please call for a 5 minute visit with one of our doctors. We will get you in as soon as possible; usually the same day you call.

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

Telephone 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.

House Calls can be arranged with your physician, but cannot be charged to insurance.

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 35.00 fee charged for cancellations made with less than 24 hour notice.

Over please…

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

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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Name_____
Address_____City_____State____Zip_____
SSN_____ Male [] Female [] Birthdate_____
Relationship status: S, M, S/D, W Spouse/Partner name:_____
Home Phone_____ Work Phone_____ (OK to leave messages at these?)
Patient's or parent's employer_____
If patient is a student, name of school/college _____City_____
Person to contact in case of emergency_____ Phone _____

RESPONSIBLE PARTY
Person responsible for this account _____ Relationship to patient _____
Address_____ Home phone_____
Employer_____ Work phone_____
Is this person currently a patient at our office? Yes [] No []

INSURANCE INFORMATION
Name of insured_____ Relationship to patient _____
Birthdate_____ Social Security Number_____
If insurance provided through employer:
Name of employer _____Work phone_____
Address of employer_____City_____State_____Zip_____
Insurance company_____Group # _____Union or local # _____
Ins. Co. address _____City_____State_____Zip_____
How much is your deductible?_____How much have you used?_____Max. annual benefit_____
Do you have additional insurance? Yes [] No [] If yes, please complete the following:
Name of insured_____ Relationship to patient_____
Birthdate_____ Social Security Number_____
Name of employer_____ Work phone _____
Address of employer_____City_____State_____Zip_____
Insurance company _____ Group # _____Union or local # _____
Ins. Co. address _____City_____State_____Zip_____
How much is your deductible?_____How much have you used?_____Max. annual benefit_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Signature of patient or parent if minor Date

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., or Emily Sharpe, 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 in ink. This is a confidential record of your health history.

Today's date: _____
Name (Last, First, M.I.)_____Date of birth_____Age_____
Do you have children?_____ Ages?_____ Relationship status: S, M, S/D, W
What are your goals for the visit today? 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_____
Date of last dental exam:_____ 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:_____
_____
_____
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? _____

Over please…….

Name _____

Name_____

Diet:
Are you vegetarian – vegan –avoiding allergens –?_____
What do you eat and drink typically?
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)_____

Review of Systems:
Do you have now, or have you had within the past year (please mark all appropriate conditions):

_____Weakness or paralysis
_____Joint pain or stiffness
_____Swollen joints
_____Muscle cramps or spasms
_____Leg cramps walking or at night
_____Easy bleeding or bruising
_____Chest pain or discomfort
_____Heart palpitations/fluttering
_____Eye pain
_____Double vision
_____Infected eyes
_____Blurred vision
_____Date of last eye exam
_____Wear glasses or contacts
_____Ear pain
_____Decrease in hearing
_____Ringing in the ears
_____Discharge from ears
_____Purple fingers or lips
_____Shortness of breath
_____Wheezing
_____Bloody sputum
_____Persistent hoarseness
_____Chronic or frequent cough
_____Frequent colds
_____Loss of smell
_____Sore throat
_____Sore tongue or gums
_____Difficulty breathing
_____Migraines

_____Enlarged veins
_____Sensitivity to heat/cold
_____Night sweat/hot flashes
_____Tire easily or weakness
_____Frequent nosebleeds
_____Skin trouble or changes
_____Change in nails or hair
_____Breast lump/discharge
_____Recent weight changes
_____Increase in thirst
_____Change in appetite
_____Heartburn
_____Difficulty swallowing
_____Frequent belching
_____Nausea
_____Abdominal cramping
_____Vomiting
_____Vomit/cough up blood
_____Constipation
_____Rectal bleeding
_____Black tarry stools
_____Hemorrhoids
_____Diarrhea
_____Dark urine
_____Frequent urination/night
_____Frequent urination/day
_____Painful urination
_____Leakage of urine
_____Blood in urine
_____Difficulty starting urine
_____Yellow jaundice

_____Skin rash
_____Seizures
_____Depression
_____Memory loss
_____Lack of sex drive
_____Dizziness/fainting
_____Sleeplessness
_____Poor coordination
_____Persistent fever
_____Headaches

Men only:
_____Discharge from penis
_____Pain/lump in testicles
_____Impotence

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?
_____Painful intercourse?

Please continue on next page…

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 safe 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?_____

Past Medical History:

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

_____Measles
_____Mumps
_____Chickenpox
_____Whooping Cough
_____Scarlet Fever
_____Pneumonia
_____Rheumatic Fever
_____Strep Throat
_____Arthritis
_____Venereal Disease
_____Anemia
_____Bladder Infections
_____Epilepsy
_____Asthma
_____Date of last chest x-ray

_____Migraine headaches
_____Tuberculosis
_____Diabetes
_____Cancer
_____Polio
_____Glaucoma
_____Hernia
_____Blood or Plasma transfusions
_____Back trouble
_____High or low blood pressure
_____Heart disease

_____Hives or Eczema
_____AIDS or HIV+
_____Infectious Mono
_____Bronchitis
_____Mitral Valve Prolapse
_____Stroke
_____Hepatitis
_____Ulcer
_____Kidney Disease
_____Thyroid Disease
_____Bleeding tendency
_____Any other disease (please list) _____
_____

Family Medical History:

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

_____High blood pressure
_____Bleeding tendency
_____Drug/alcohol problem
_____Chronic lung disease
_____Mental Illness
_____Migraine headaches
_____Thyroid disease
_____High cholesterol

_____Tuberculosis
_____Heart disease
_____Epilepsy
_____Cancer
_____Leukemia
_____Ulcer
_____Gout
_____Kidney disease

_____Diabetes
_____Stroke
_____Allergies
_____Asthma
_____Obesity
_____Depression
_____Glaucoma
_____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_____ _____
Signature of patient Date