

New IV Patient Health Record

At Water's Edge, our naturopathic doctors take the time to learn all about your health history and help you achieve your wellness goals with the use of IV therapy. Please complete and return this **Patient Health History form** to tell us important information about you.

NP

**Please call our office and schedule a new patient appointment *before* you fill out and submit this questionnaire.**

**Return your completed form to us at least 48 HOURS before your first appointment.**

**How to complete and return this form to us:**

1. Complete the form using Microsoft Word. Save the file with a new filename that includes **your name** (e.g., "*New-IV-*Patient-Health-Record-MarySmith.doc").
(NOTE: Please do not convert it to another format such as HTML.)
2. Return the form to us by mail or fax:

Send to: 1000 2nd Ave, Suite 2920 Seattle, WA 98104

FAX: 206.283.1924

**NOTE**: If you are unable to send this form in email, please print your completed form and mail it to our office at the address below. \*\***Be sure to mail it at least 5 days before your appointment, so we receive it 24-48 hours in advance**.

If you have any questions, please call us at **206. 283. 1383**.

Thank you, and we look forward to working with you!



New IV Patient Health Record

New Patient Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NP

|  |  |  |
| --- | --- | --- |
| Patient’s Information |  | Account Information |
| Name Prefer to be called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse/Partner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address City State Zip \_\_\_\_\_\_\_\_Home Phone Work Phone E-mail Address Birth Date Age \_\_\_\_\_\_Gender: ¨ Female ¨ Male Marital Status: ¨ Married ¨ Partnered ¨ Single ¨ Divorced ¨ Widowed ¨ Separated  | Person responsible for the account \_\_\_Occupation Employer Business Address City State Zip Business Phone  |
| Your Spouse/Partner |
| Occupation Employer Business Address City State Zip Business Phone  |
| General Information |
| Do you have a Primary Care Doctor? ¨ No ¨ YesPhysician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you consulted a doctor about your current condition(s)? ¨ No ¨ YesPlease state diagnosis, therapy and the results:  |
| Person to Contact in Case of Emergency |
| Name Relationship Address City State Zip Telephone  |

**Authorization for Treatment**

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Naturopathic Care.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History**

Patient’s Name Date

Number of Children Names & Ages

Current Health Condition

(Please list your present health problems and concerns.)

|  |  |
| --- | --- |
| **Problem or Concern** | **Date of Onset** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

Please list the most significant, stressful events in your life, from the most recent to the most distant.

Are any of these situations continuing to impact your life? If so, please indicate these clearly.

|  |  |
| --- | --- |
| **Event** | **Continuing?** |
|  | ¨ Continuing |
|  | ¨ Continuing |
|  | ¨ Continuing |
|  | ¨ Continuing |

Family Medical History

From the following list, please write next to each family member all conditions that apply.

|  |  |  |
| --- | --- | --- |
| **Conditions** |  | Family members affected |
| AIDS | HIV+ |  | Mother: |
| Alcoholism | Kidney disorder |  |  |
| Allergies  | Mental illness |  |  |
| Anemia | Migraines |  | Father: |
| Arthritis | Obesity |  |  |
| Asthma  | Osteoporosis  |  |  |
| Breast Cancer | Psoriasis  |  | (Maternal) Grandparents: |
| Cervical Cancer | Senility |  |  |
| Ovarian Cancer | Seizures |  |  |
| Prostate Cancer | Sexually Transmitted Disease |  | (Paternal) Grandparents: |
| Uterine Cancer | Skin problems |  |  |
| Other Cancers (list types) | Stroke |  |  |
| Diabetes | Suicide |  | Siblings: |
| Eczema | TB |  |  |
| Gout | Thyroid problems |  |  |
| Heart Disease | Ulcer |  | Other Family: |
| Hemophilia | Other  |  |  |
| High blood pressure |  |  |  |

Name Date

Medications and Hospitalizations

Please include all your current **prescription medications** (sleeping pills, birth controls pills), **non-prescription medications** (aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc. (**Include dose for each**.)

Attach a separate sheet, if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose per day** | **Reason for use** | **Prescriber** | **Date started Med.** |
|  |  |  |  |  |
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|  |  |  |  |  |
| **Hospitalization, surgeries or serious injuries (dates and types of illness or operation):** |
|  |
|  |
|  |

Allergies

|  |  |
| --- | --- |
| **Drugs, food or other substances** | **Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Name Date

Health Data

**(Please fill in completely)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Exam** | **Date** | **Result** | **Due** | **Screening Recommendations** |
| Last Pap Smear/Gynecologic Exam |  |  |  | Yearly starting after first intercourse or age 21 |
| Mammogram |  |  |  | Yearly starting at age 40 |
| Bone Density Test (DEXA) |  |  |  | Every 2 years starting at age 50 |
| Colonoscopy |  |  |  | Every 10 years starting at age 50 |
| Prostate or Testicular Exam |  |  |  | Yearly for men starting at age 40 |
| **Other** | **Date** | **Location** | **Result** |
| Physical Exam |  |  |  |
| Foreign Travel History & Immunizations |  |  |  |
| Tuberculosis (TB) skin test |  |  |  |
| Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.) |  |  |  |
| Other |  |  |  |

Health History

Please check any conditions you **currently** **have** or **have had in the** **past year ONLY**.

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | **Gastrointestinal** | **Eye/Ear/Nose/Throat** | **Cardiovascular** |
| ¨ Chills¨ Depression¨ Dizziness¨ Fainting¨ Fever¨ Forgetfulness¨ Headache¨ Loss of sleep¨ Nervousness¨ Numbness¨ Sweats | ¨ Poor Appetite¨ Bloating¨ Bowel changes¨ Constipation <1 stool/day¨ Diarrhea¨ Excessive hunger¨ Excessive thirst¨ Gas¨ Hemorrhoids¨ Indigestion¨ Nausea¨ Rectal bleeding¨ Stomach pain¨ Vomiting¨ Vomiting blood¨ Parasites | ¨ Bleeding gums¨ Blurred vision¨ Crosses eyes¨ Difficulty of swallowing¨ Double vision¨ Ear ache¨ Ear discharge¨ Hay fever¨ Hoarseness¨ Loss of hearing¨ Nosebleeds¨ Ringing in the ears¨ Sinus infections¨ Vision “flashes”¨ Vision “halos” | ¨ Chest pain/pressure¨ High blood pressure¨ Irregular heart beats¨ Low blood pressure¨ Poor circulation¨ Rapid heart beat¨ Varicose veins¨ Edema |

Name Date

**Health History** (continued)

Please check any conditions you **currently** **have** or **have had in the** **past year ONLY**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Respiratory** | **Skin** | **Muscle/Joint/Bone** | **Genito-Urinary** |
| ¨ Shortness of breath¨ Persistent cough¨ Wheezing¨ Cough with blood | ¨ Acne¨ Bruise easily¨ Itching¨ Change in mole(s)¨ Rash¨ Scars¨ Sore that won’t heal | Pain, weakness, or numbness in:¨ Arms¨ Back¨ Feet¨ Hands¨ Hips¨ Legs¨ Neck¨ Shoulders¨ Loss of height | ¨ Blood in the urine¨ Frequent urination¨ Lack of bladder control¨ Painful urination |

Please CHECK any conditions you **currently have** or **have ever had**.

|  |  |  |
| --- | --- | --- |
| ¨ AIDS | ¨ Frequent antibiotic use | ¨ Panic attacks |
| ¨ Alcoholism | ¨ Hay fever  | ¨ Parasites |
| ¨ Allergies | ¨ Headaches | ¨ Pneumonia |
| ¨ Anemia | ¨ Hemorrhoids | ¨ Prostate problems |
| ¨ Anorexia | ¨ Hemophilia | ¨ Psoriasis |
| ¨ Appendicitis | ¨ Problems with gums and teeth | ¨ Psychiatric care |
| ¨ Arthritis | ¨ Gall bladder problems | ¨ Rheumatic fever |
| ¨ Asthma | ¨ Glaucoma | ¨ Spontaneous abortion (miscarriage) |
| ¨ Bladder/urinary problems | ¨ Goiter | ¨ Seizures |
| ¨ Bleeding disorders | ¨ Gout | ¨ Sexual abuse |
| ¨ Breast lump | ¨ Hair falling out | ¨ Sinusitis |
| ¨ Bronchitis | ¨ Heart Disease  | ¨ Skin problems |
| ¨ Bulimia | ¨ Hernia | ¨ Stroke |
| ¨ Cataracts | ¨ High Cholesterol | ¨ Suicidal attempt |
| ¨ Cancer (list type) | ¨ Hypoglycemia | ¨ Thyroid problems |
| ¨ Chemical dependency | ¨ Irritable bowel/colitis | ¨ Tonsillitis |
| ¨ Diabetes | ¨ Jaundice | ¨ Ulcers |
| ¨ Digestive disorders | ¨ Joint problems | ¨ Varicose veins |
| ¨ Ear problems | ¨ Kidney disease | ¨ Vaginal infections |
| ¨ Edema, dropsy or water weight | ¨ Liver disease | ¨ Weight gain/weight loss |
| ¨ Eczema | ¨ Lung problems | ¨ Other: |
| ¨ Emphysema | ¨ Migraine headaches |  |
| ¨ Epilepsy | ¨ Multiple sclerosis |  |
| ¨ Eye problems | ¨ Obesity |  |
| ¨ Fatigue (chronic) | ¨ Osteoporosis |  |
| ¨ Female gynecological problems | ¨ Pacemaker |  |

Name Date

**Health History** (continued)

Please CHECK any conditions you **currently have** or **have ever had**.

|  |
| --- |
| **Infectious diseases:** |
| ¨ Chicken pox | ¨ Measles | ¨ Scarlet fever |
| ¨ Chlamydia | ¨ Mumps | ¨ Syphilis |
| ¨ Gonorrhea | ¨ Mononucleosis/Epstein-Barr | ¨ Tuberculosis |
| ¨ Hepatitis | ¨ Polio | ¨ Typhoid fever |
| ¨ Herpes | ¨ Papilloma virus | ¨ Other: |
| ¨ HIV positive | ¨ Rubella |  |

Please CHECK Yes or No for any conditions you **currently have** or **have ever had**.

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | Breast/Prostate cancer |
| **Yes** | **No** | Uterine/Cervical cancer |
| **Yes** | **No** | Currently pregnant |
| **Yes** | **No** | Currently breastfeeding |
| **Yes** | **No** | Heart or Liver or Kidney disease |
| **Yes** | **No** | Thrombophlebitis (deep vein pain/clotting issue) |
| **Yes** | **No** | Thromboembolic disorder (blood clotting problem) |
| **Yes** | **No** | Estrogen-related cancer |
| **Yes** | **No** | Undiagnosed abnormal genital bleeding |
| **Yes** | **No** | Family history of Breast cancer |
| **Yes** | **No** | Family history of Uterine cancer or Cervical cancer or Prostate cancer |
| **Yes** | **No** | Breast cysts, breast nodules, fibrocystic breasts, abnormal mammogram |
| **Yes** | **No** | Severe liver disease |
| **Yes** | **No** | History of severe hypersensitivity to drugs |
| **Yes** | **No** | Genital cancer (Vaginal or Testicular cancer) |
| **Yes** | **No** | Use of blood thinning medications |
| **Yes** | **No** | Severe reaction to estrogen or progesterone or testosterone or DHEA or Cortisol |
| **Yes** | **No** | Currently active cancer |
| **Yes** | **No** | Myocardial infarction or other acute heart disease  |
| **Yes** | **No** | High blood pressure or intracranial hypertension  |
| **Yes** | **No** | BPH (Benign Prostatic Hypertrophy) causing obstructed urine flow  |

If you answered **Yes** to any of the above, please describe in detail.

|  |
| --- |
|  |
|  |
|  |
|  |

Name Date

Hormone Medication History

**Please complete the following table, using the examples below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hormone** | **DHEA** | **Progesterone** | **Estrogen** | **Testosterone** |
| Hormone Name |  |  |  |  |
| Dosage |  |  |  |  |
| Date Started |  |  |  |  |
| Date Ended |  |  |  |  |
| Using Currently |  |  |  |  |
| Days of month used |  |  |  |  |
| Natural |  |  |  |  |
| Synthetic |  |  |  |  |
| Cream |  |  |  |  |
| Suppository |  |  |  |  |
| Caps/Tablets |  |  |  |  |
| Drops |  |  |  |  |

|  |
| --- |
| Reason for use: |
| List reactions to hormones: |

**EXAMPLE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hormone** | **DHEA** | **Progesterone** | **Estrogen** | **Testosterone** |
| Hormone Name |  | Prometrium | Estradiol |  |
| Dosage |  | 100 mg | 1.0 mg |  |
| Date Started |  | 6/05 | 6/05 |  |
| Date Ended |  |  |  |  |
| Using Currently | No | Yes | Yes | No |
| Days of month used |  | Days 15-30 | Days 1-20 |  |
| Natural |  |  |  |  |
| Pharmaceutical |  | Yes | Yes |  |
| Cream |  |  |  |  |
| Suppository |  |  |  |  |
| Caps/Tablets |  | Yes | Yes |  |
| Drops |  |  |  |  |

Name Date

**Personal Health Habits**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Height: | Current Weight (lbs):  | 1 Year Ago (lbs):  | Max. Weight (lbs):  | Date: |
| **Item** | **No** | **Yes** | **Details** |
| Tobacco Use |  |  | Smoke or Chew: Years: | Amt Per Day: | Year Quit: |
| Alcohol Use |  |  | Type: | Drinks per week: |
| Rec. Drug Use |  |  | Type: | Frequency: |
| Coffee: |  |  | Cups Per Day: | Caffeinated or Decaf:  |
| Tea |  |  | Cups Per Day: | Caffeinated or Decaf: |
| Sodas |  |  | Type: | Cans Per Day: |
| Chocolate |  |  | How Often: |
| Exercise |  |  | Type:  | Frequency: | Duration: |

**Occupational and Household Exposure**

|  |  |
| --- | --- |
| What is your occupation? | Average hours you work per week: |
| Please describe your work: |
| **Situation** | **No** | **At Times** | **Yes** | **Details** |
| Do you work in the presence of toxic fumes or chemicals?  |  |  |  |  |
| Have you ever worked near toxins? |  |  |  | If yes, please provide details: |
| Are you exposed to second-hand smoke?  |  |  |  |  |
| Do any of your hobbies involve toxic materials?  |  |  |  | If yes, what kind (paints, plastics, gases, lead, etc.): |
| Do you wear sunglasses, contact lenses, or glasses when outside?  |  |  |  |  |
| Do you have house pets? |  |  |  | Type: |

Detoxification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Situation** | **No** | **At Times** | **Yes** | **Details** |
| Have you ever participated in a detox program supervised by a qualified health professional? |  |  |  | If yes, please explain: |
| Do you fast? |  |  |  |  |
| Do you feel well rested on waking in the morning (ready to get up and going)? |  |  |  |  |
| How many hours do you sleep on the average night?  |
| On a scale from 1 to 10, how do you rate the quality of your sleep? (0 = no sleep and 10 is great):  |

Name Date

Digestion and Eating Habits

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Description of diet** | **No** | **At Times** | **Yes** | **Details (Describe each meal below)** |
| Do you eat **breakfast**? |  |  |  |  |
| Do you eat **lunch**? |  |  |  |  |
| Do you eat **dinner**? |  |  |  |  |
| Do you eat **snacks**? |  |  |  | Number of times a day:What do you eat? |
| Do you diet often? |  |  |  |  |
| Are you on a special diet?  |  |  |  | If yes, describe: |
| What kind of foods do you **crave**?  | List: |
| What kinds of foods cause you **problems**? | Describe the food and the problem you experience when you eat it: |
| What foods do you eat every day? |  |  |  |  |
| Do you often eat at fast-food restaurants? |  |  |  |  |
| Do you often eat in restaurants? |  |  |  |  |
| Do you use NutraSweet (aspartame) or other artificial sweeteners? |  |  |  |  |
| How do your bowel movements tend to be? | ¨ Constipated ¨ Loose ¨ IBS ¨ IBD ¨ \_\_\_\_\_\_\_\_ |

Skin

|  |
| --- |
| Do you perspire when you exercise? ¨ Lightly ¨ Moderately ¨ Heavily |
| Do you perspire other than when exercising? ¨ No ¨ At Times ¨ Yes When? |
| Do you have difficulty perspiring? ¨ No ¨ At Times ¨ Yes |
| Does your perspiration smell strong? ¨ No ¨ At Times ¨ YesDoes it smell like urine? ¨ No ¨ At Times ¨ Yes |

**Life Style Index**

**Please rate your level of functioning for each area of your life on a scale of 1-10 (10 = best)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Function** | **Rating** | **Function** | **Rating** | **Function** | **Rating** |
| Mental |  | Family |  | Social |  |
| Emotional |  | Creativity |  | Spiritual |  |
| Physical |  | Fun |  | Career |  |

Name Date

**Women Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Gynecologic History** | **Yes** | **No** | **Details** |
| Age your period began: | **Abnormal Pap smear? Date:**  |
| Menopause  |  |  | If yes, date of last period:  |
| Perimenopause  |  |  | If yes, describe symptoms: |
| Ovaries removed (one/both) |  |  | If yes, when: |
| Uterus removed  |  |  | If yes, when: |
| DES – did your mother take it during pregnancy? |  |  |  |
| **Are you still menstruating?** |  |  | **If yes, complete the section below; if no, skip that section** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Menstruation** | **Yes** | **No** |  | **Yes** | **No** |
| Regular periods |  |  | Bleeding between periods |  |  |
| Irregular mensesSymptoms: |  |  | Spotting |  |  |
| Cramps / # of days: Mild\_\_\_ moderate\_\_\_ severe\_\_\_\_ |  |  | Midcycle spotting |  |  |
| PMS / # of days:Symptoms: |  |  | Spotting instead of period |  |  |
| Oral contraceptives (past/present) |  |  | Weight gain (how many lbs) |  |  |
| Periods every \_\_\_\_\_days (length of cycle) Duration: \_\_\_\_\_ days (flow days) Flow: heavy\_\_ medium\_\_\_ light\_\_\_ |
| Date your last 6 periods began: \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ |

|  |
| --- |
| **Pelvic Exam** |
| Date of last pelvic exam: | Performed by: |
| Date of last PAP smear: | Result: |
| Recurrent vaginal yeast infections Yes\_\_\_\_ No \_\_\_\_ | Are you sexually active: Yes\_\_\_\_ No \_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Breast Health** | **Yes** | **No** |  | **Yes** | **No** |
| Breast pain |  |  | Fibrocystic breast disease |  |  |
| Breast lumps  |  |  | Do you perform monthly breast exam on yourself?  |  |  |
| History of abnormal mammogram |  |  | Currently breastfeeding |  |  |
| Nipple discharge |  |  | Breast implants / Type:  |  |  |
| **Date of last mammogram: Results: Location of diagnostic center:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pregnancy** | **Yes** | **No** |  | **Yes** | **No** |
| Currently pregnant |  |  | Planning pregnancy (If yes, when: ) |  |  |
| Desire pregnancy |  |  | Pregnancy complications (If yes, describe) |  |  |
| Prior pregnancies: #\_\_\_ Births #\_\_\_ C-Sections #\_\_ Miscarriages #\_\_\_ Abortions #\_\_\_\_ |

Name Date

**Female Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **if it’s present** by rating it on a **Wellness Gauge Scale** **0 to 10
when 0 = symptom is not present ☺ and 10 = symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Fibroids |  | Mood swings |
|  | Allergies |  | Fluid retention |  | Night sweats |
|  | Anger easily |  | Food cravings/binge eating |  | Ovarian cyst(s) |
|  | Back pain |  | Heavy menstrual bleeding |  | PMS |
|  | Bloating |  | Vaginal dryness |  | Rheumatoid arthritis |
|  | Chronic stress |  | Hot flashes |  | Skin problems |
|  | Depression |  | Insomnia |  | Spotting |
|  | Disinterest in sex/low sex drive |  | Irregular menstrual cycle |  | Subfertility |
|  | Endometriosis |  | Irritable or anxious |  | Other: |
|  | Fatigue |  | Meat eater (rate frequency) |  |  |
|  | Fibrocystic breast disease |  | Menstrual migraines |  |  |
|  | **TOTAL SCORE:** |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Ovarian Cancer |  | Infertility (never able to conceive) |
|  | Uterine Cancer |  | Loss of height/ bone loss |
|  | Cervical Cancer |  | Miscarriage |
|  | Breast Cancer |  | Premature menopause (<45 yrs old) |
|  | Estrogen/Progesterone sensitive Cancer |  | Pain with intercourse |
|  |  |  | **TOTAL SCORE:** |
|  | **GRAND TOTAL SCORE:** |

|  |
| --- |
| **Are you completely satisfied with your sexual experience:** Yes\_\_\_\_ No \_\_\_\_ |
| Please explain: |
|  |
|  |

Name Date

**Men Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Breast lump |  |  | DES – did your mother take it during pregnancy? |  |  |
| Lump in testicle |  |  | Date of last genital exam: |  |  |
| Penis discharge  |  |  | Date of last prostate exam: |
| Sore on the penis  |  |  | Date of last PSA test: Result: |
| Erection difficulties  |  |  |  |

**Male Hormone Imbalance Rating**

Please rate the severity of the symptom(s) or condition **when it’s present** by rating it on a **Wellness Gauge Scale 0 to 10,
when 0= symptom is not present ☺, 10= symptom is severe ☹**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Thinning armpit, head, pubic hair |  | Urine flow dribbling at the end |
|  | Joint pain/Stiffness |  | Skin problems/dryness |  | Blood in urine |
|  | Anger easily |  | Excessive sweating (day or night)  |  | Urinary incontinence |
|  | Back pain |  | Mood swings |  | Pain with urination |
|  | Rheumatoid arthritis |  | Lack interest in leisure/social activities |  | Pain with ejaculation |
|  | Chronic stress |  | Low stamina |  | Bloody ejaculation |
|  | Depression |  | Difficulty obtaining erection |  | Pain with intercourse |
|  | Disinterest in sex/low sex drive |  | Difficulty maintaining erection |  | Unable to conceive (subfertility) |
|  | Erectile dysfunction |  | Pain with erection |  | Mass in genital organs |
|  | Fatigue |  | Lack of nocturnal erections |  | Heavy drinking (past/ present) |
|  | Insomnia |  | Lack of morning erections |  | Frequent urination  |
|  | Irritable or anxious |  | Urine flow slow to start |  | Other: |
|  | Food cravings/binge eating |  | Weak urine stream |  |  |
|  | Breast enlargement |  | Unable to void bladder completely |  |  |
|  | **TOTAL SCORE:** |

**Past or Present Condition (0 = none, 10 = yes)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | History of mumps infection |  | Infertility (never able to conceive) |
|  | History of mass in genitalia |  | Loss of height/bone loss |
|  | History of testicular/scrotal surgery |  | Cancer: (list type) |
|  | Developmental issues w/sex organs |  | Other: |
|  | Family history of prostate cancer |  | **TOTAL SCORE:** |
|  | **GRAND TOTAL SCORE:** |

**Office Guidelines**

Please read and sign our office guidelines to ensure we share a common understanding. We welcome any questions you may have, and if there’s anything we haven’t covered, please feel free to ask. We want to have all your questions answered so we can move ahead with your healing process. Thank you-- we look forward to helping you!

**Payment for IV Therapy and Health Products**

* **Full payment is required at the time of service**. It has been our experience that people get well faster if they don’t have to worry about doctor bills piling up. **Initial:\_\_\_\_\_\_**
* **All Meyers cocktails will be paid in full at the time your IV infusion appointment is made**. **Payment method on file will automatically be processed unless another method is provided. Initial:\_\_\_\_\_\_**

**Payment Method**

* Water’s Edge accepts all major credit cards/debit, check or cash. Please note the credit card machine adds a 3% surcharge on credit cards and no surcharge on debit cards. There will be a $40.00 charge for returned checks. **Initial for Acknowledgement: \_\_\_\_\_\_**

**Office Hours, Appointment Cancellations, Reschedules, No Shows**

* Hours may vary due to holidays and clinic closures. Whenever possible we post notification of changes to our regularly scheduled ours.
* If you need to cancel or change a scheduled appointment, please call Monday - Friday during or before office hours, (2) or more business days before your appointment.
* **If a change is made with less than 48 hour business notice, you will be charged the full visit fee. Meyers cocktails typically expire 2 weeks after ordered. If your appointment is rescheduled outside of the expiration date a new order will need to be placed and paid in full. There will be no refund for an expired IV. Initial:\_\_\_\_\_\_**

**Refilling and Mailing your Medications**

* You may come to our clinic any time during normal business hours to purchase supplements prescribed for you**.** **Initial:\_\_\_\_\_\_**
* We are happy to mail medications your doctor has prescribed for you. A handling charge is added to the postage fee for all mailings, to cover the cost of shipping supplies. Orders are generally processed 24 to 48 business hours from when they are placed. Requests made on Thursday after 12 pm PST, will not go out until the following week. Mailed items must be paid for at the time of the order**. Please note we cannot be responsible for lost packages; *if you request a mailing or drop box you assume the risk and cost.* Initial for Acknowledgement: \_\_\_\_\_\_**
* In addition, for any orders placed over the phone or email, our staff will charge credit card on file. **Please specify which credit card you would like to use and if it is a pick-up or mail out.**
* You may return any unopened, unexpired medicines purchased within 45-days; after that, all sales are final. There will be a 10% restocking fee for all dispensary returns. For online orders returned to the office, there will be a 10 % restocking fee and shipping fee deducted from the return. **Initial:\_\_\_\_\_\_**
* All labs are non-refundable once processed and charged. **Initial:\_\_\_\_\_\_**

I accept the above Office Guidelines. **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Consent for Leaving Messages/Share Information with Family/Friends**

I understand that my healthcare information at Water’s Edge Natural Medicine is protected, and I have received a copy of the Notice of Privacy Practices.

In order for the clinic to leave detailed messages on my voice mail or answering machine, I need to give permission to Water’s Edge Natural Medicine.

**Consent for Leaving Messages** (please check box)

 □ Yes □ No best number to leave messages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I consent to information regarding myself (or my child’s) appointment reminders/instructions

 be left on my voicemail or answering machine.

**Consent for Shared Information with Family and Friends** (please check box)

 □ Yes □ No

 I wish family members or friends to have access to my healthcare information. The name(s)

 listed below are family members or friends to whom I grant access to my healthcare information.

 I will rely on the professional judgment of my provider and her designee to

 share such information as they deem necessary.

I understand that information is limited to verbal discussions; no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME RELATIONSHIP

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name Patient/Parent Signature**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships change and may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

**Authorization for Treatment**

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the standards of Naturopathic Care.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent of Responsible Party (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor and Patient Information and Responsibilities for patients of Water’s Edge Clinic**

As a Doctor:

* I will treat you with compassion and respect. I will listen and communicate well.
* I will respect your health choices and preferences.
* I can work as part of a health team, communicating and referring to other providers.
* I will be prompt in answering your phone messages via my staff.
* I will go to seminars, lectures and keep current in my fields of training and interest.
* I will let you know what I think is causing your symptoms, as well as what the options are for diagnosis and treatment.
* I will think about the complex inter-relationships in your body and will work on improving function, decreasing symptoms as well as optimizing wellness.
* I will think about prevention of heart disease and cancer if you tell me this is a priority for you.
* I will consider lifestyle interventions as well as other interventions that could benefit you.
* I can provide you, at the initial office call, with an estimate of costs and upon request.
* The front desk, with my assistance, will prepare an invoice with the appropriate diagnosis and procedure codes for your visit and services, which you can submit to your insurance provider.

**Information and responsibilities for you as patient:**

I as patient agree to:

* Know that my body is unique and may react in unique ways to treatment.
* I will treat you and the office staff with compassion and respect. I will listen and communicate well.
* Avoid blaming you for my health problems and symptoms during my treatment and know that we are a team working together to advise, coach, and improve me.
* Take charge of my attitude and work on improving it in regard to my physical, emotional, or financial health.
* Let you know if there are ways to communicate with me better.
* Tell you my goals and priorities for each visit as well as my long-term health goals (if appropriate).
* Give you feedback as to how things are going for me and how things could go better.
* Let you know if I have a side effect from anything.
* Do my “health homework” (exercises, diet, supplements, lab etc.) to the best of my abilities or not do something if I have side effects from it.
* Tell you at the time of my visit (or by phone or fax) if I do not agree with something or do not want a test, physical exam, medication, or supplement.
* **Have another doctor on my team in case of an emergency if you are not reachable.**
* **Call the office if I am running late.**
* **Office policies hold for less than 48-hour notice on cancellations.**
* Take the responsibility for scheduling my appointments and for scheduling my health homework to make the changes successfully that I want.
* Know that I have the right to obtain the kind of healthcare that I need. If I choose to pay for healthcare outside of my insurance, that is my decision and option for my well-being. As a patient I am aware that I have the right to invest in my healthcare needs even if my insurance does not or only partly reimburse me.
* Investing in my body now can have a big payoff in the future, saving me money in the long run.

I have read the above and agree with it. I know I can make additions or changes in the section above.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

**We are required by law to:**

* Make sure that health information that identifies you is kept private
* Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
* Follow the term of the Notice that is currently in effect

**How we may use and disclose health information about you:**

* For treatment
* For payment
* For health care operations
* For appointment reminders
* As required by law
* To avert a serious threat to health and safety
* As required by the Military of Veterans and Workers
* Public Health risks
* Health oversight activities
* Lawsuits and disputes
* Law enforcement
* Coroners, health examiners, and funeral directors
* National Security and Intelligence activities
* Protective Services for the President and others
* Security Officials for Inmate

**Your rights regarding health information about you:**

* Right to inspect and copy
* Right to amend
* Right to an accounting of disclosures
* Right to request restrictions
* Right to request confidential communications
* Right to a paper copy of this notice

**Complaints:**

If you believe your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing.

**Acknowledgements of receipt of this Notice:**

We will request that you sign on a separate form acknowledging you have received a copy of this notice. The acknowledgement will become a part of your records

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),

I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
* Obtain payment from third party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *HIPAA Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *HIPAA Notice of Privacy* Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *HIPAA Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

**RECORDS RELEASE AUTHORIZATION**

I hereby authorize: WATER’S EDGE NATURAL MEDICINE To release the following confidential medical information from the health record of Name/Date of Birth:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Copy of complete health record From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Lab results (specify)

\_\_\_\_\_X-Ray reports/film (specify)

\_\_\_\_\_Other (specify)

Information is to be released to (self or other):

Paper copies of medical records may be released upon receipt of written authorization of patients over the age of 18 or a legal guardian. Once authorization is received, it may take *up to 10 business days* to process your request.

There is a charge to obtain copies of medical records. If requested for private use by patients or guardians:

* No charge to the patient when records are sent via fax.
* No charges for page count if 10 pages or less.
* $0.20 per page for 10 pages and over plus shipping/handling.

If the records are needed for continuing care, there is no charge to the patient when records are sent (via fax) directly to your *physician* or the *facility providing treatment*. If records are needed for treatment or for an appointment within the next 48-72 hours, physicians can request records by fax when you arrive in his/her office for treatment.

**This authorization is valid for 365 days from the date signed**. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I also understand that my records are protected under the federal and state confidentially regulations and cannot be disclosed without my written consent otherwise provided for in the regulations.

**Patient/Guardians Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NOTE: Records containing information in relation to drug, alcohol, mental health and sexually transmitted diseases testing, diagnosis and treatment require a SPECIAL AUTHORIZATION.

**General guidelines for the patient portal**

**Messaging your health care provider:**

* Please do not use the messaging portal. The portal messaging system is not set up for smooth communication between patients and doctors. If you need to leave a medical question or concern, give our office a call at 206.283.1383. Please allow up to 48 business hours for a response, or if you have a new health concern, an appointment may be necessary to ensure that you receive the best care possible in a timely manner.  Thank you for understanding and being patient.
* If you need a physician’s advice for an **urgent medical concern**outside of business hours, call 206.283.1383 press option 3. Please note that there is a $80 fee for this service. Otherwise, please call the office at 206.283.1383 to schedule an appointment during business hours.
* For all supplement refills, please send an e-mail to Reminders@naturoapthic.com.

**Lab Results, Treatment plans, or Medical records:**

* Medical records will be released on the portal by request only. You will have to request your records 7 to 10 business days before a scheduled appointment. Please make sure your records request form is up to date. You can contact the front office for the records release form.
* If you would like to send us medical records, you can do so via the patient portal.

**Appointment reminders:**

* To Opt-in for Text Message and e-mail Reminders, please confirm your **mobile** number and **e-mail** with the Front Desk.
* If you would prefer a **phone call** **reminder** instead of an e-mail or text message, please let the front desk know you would like to opt-out of text message and e-mail reminders.