willamette integrative health

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P/ 971-245-2185 ▪ F/ 971-248-2096 ▪ willametteintegrative.com

THIS FORM IS DUE AT LEAST 24 HOURS BEFORE THE FIRST APPOINTMENT.

PATIENT INFORMATION

Patient name	last	first	middle initial
Date of birth	**Age**	**Sex**	**Social security #**
Mailing address			
City, State, Zip		**Email**	
Telephone	cell	home	☐ voicemail ok ☐ text ok
Race ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White		**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Emergency contact	relationship	phone	
How did you hear about our practice?			

INSURANCE INFORMATION

☐ **I will pay in full at time of service.** ☐ **Please bill my insurance. I have verified my benefits and I will present my card.**

Name of insured		sex	relationship to patient
DOB	SSN	address	
Member ID #	Group #		
Insurance company		insurance phone	
Claims address			
Copay	Deductible	Amount met	Reset date

ASSIGNMENT OF BENEFITS (FOR INSURANCE BILLING) **initials** _____

I hereby authorize Willamette Integrative Health to submit claims to my insurance carrier for all services rendered. I authorize the release of medical information necessary to process these claims. I direct third party payers to issue payment directly to Willamette Integrative Health, LLC. I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the medical services received.

CONDITIONS OF PATIENT REGISTRATION

MEDICAL CONSENT **initials** _____

I consent to the provision of health care services at Willamette Integrative Health and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions. I understand this care may include examinations, lab tests, imaging, medical and surgical treatments, and related anesthesia. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider(s) during each visit.

FINANCIAL POLICY **initials** _____

I have been offered a copy of the Financial Policy and I have reviewed and agree to the policy. I agree to promptly pay all fees and charges for treatment provided to me and/or my family. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. If I disagree with any charges I will contact Willamette Integrative Health within 30 days of billing.

HIPAA PRIVACY POLICY and COMMUNICATIONS POLICY **initials** _____

I have been offered a copy of the Notice of Privacy Practices and the Communications Policy and I have reviewed and agree to these policies. (These documents are available at http://willametteintegrative.com under "Clinic Policies" – or please ask for a paper copy in the office).

I have read and fully understand all of the information above as conditions of my registration.

_____ _____ _____

name of patient (please print) **signature** of patient or guardian **date**

CONTEXT OF CARE	
primary care doctor or practice	
other doctors or practitioners	
preferred pharmacy	**preferred hospital**

We are so glad to welcome you to Willamette Integrative Health! Why did you choose to seek care with us?

_____

How would you rate your overall health? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = highest

Please list your top 4 biggest health concerns.

1. _____
2. _____
3. _____
4. _____

What are your expectations for your first visit? _____

What are your expectations for our work together in general? _____

_____

What is your level of commitment to achieving these goals? _____

MEDICATIONS AND ALLERGIES				
name of medication or supplement	**dose and frequency**	**reason for taking**	**date started**	**prescribed by**

(if this space is not sufficient, please attach extra pages).

allergy	**reaction**	**severity**

PAST MEDICAL HISTORY

Surgeries or hospitalizations (include year): _____

_____

Past or current major illnesses (if not listed above): _____

Childhood illnesses: ☐ chickenpox ☐ mononucleosis ☐ others: _____

Other childhood history: ☐ C-section ☐ difficult birth ☐ tonsillectomy ☐ ADD/ADHD ☐ dyslexia

Childhood immunizations: ☐ all received ☐ never received the following: _____

Adult immunizations: last tetanus booster (date): _____ ☐ annual flu shot ☐ shingles ☐ hepatitis B series ☐ travel vaccines: _____ ☐ others: _____

FAMILY HISTORY

Please list age, major health issues (especially heart disease, diabetes, autoimmune disease, cancer), and cause of death if deceased.

Mother _____

Maternal grandmother _____

Maternal grandfather _____

Father _____

Paternal grandmother _____

Paternal grandfather _____

Sister(s) _____

Brother(s) _____

Child(ren) _____

Other _____

SOCIAL HISTORY

Are you ☐ single ☐ dating ☐ in a partnership ☐ married ☐ separated ☐ divorced ☐ widowed	
Living with ☐ alone ☐ spouse/partner ☐ parents ☐ children ☐ relatives ☐ friends ☐ other	
Employment ☐ employed full-time ☐ employed part-time ☐ student ☐ unemployed ☐ retired	
Occupation	**Employer / School**

Significant sources of stress in your life: ☐ work ☐ family ☐ social ☐ financial ☐ other _____

Do you have people in your life who support you? ☐ YES ☐ NO Do you feel safe at home? ☐ YES ☐ NO

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day
- Feeling down, depressed, or hopeless ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Please describe any religious or spiritual practices: _____

How do your beliefs impact your healthcare decisions? _____

diet and exercise

Are you satisfied with the way you eat? ☐ YES ☐ NO Why? _____

Appetite: ☐ high ☐ moderate ☐ low Food cravings? _____

Thirst: ☐ high ☐ moderate ☐ low Food restrictions? _____

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Snacks: _____

Water: _____

Other beverages: _____

Alcohol: ☐ wine ☐ beer ☐ spirits How much/how often? _____

Tobacco: ☐ current everyday smoker ☐ current occasional smoker Packs per day _____ # years _____

☐ former smoker (years since quitting _____) ☐ never smoker Currently trying to quit? ☐ YES ☐ NO

Other substance use: _____

Exercise and fitness: _____

Relaxation and hobbies: _____

sleep and energy	
Average number of hours sleep per night:	Do you wake refreshed? ☐ YES ☐ NO
Insomnia: ☐ trouble falling asleep ☐ trouble staying asleep What keeps you awake?	
Average energy level throughout the day: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = highest	
Best energy time of day:	Worst energy time of day:

home and travel	
Water source: ☐ plain tap ☐ filtered tap ☐ distilled ☐ bottled ☐ well water ☐ other:	
Food prep and storage: ☐ microwave ☐ non-stick pots and pans ☐ aluminum pans ☐ plastic storage containers	
Home and work well ventilated? ☐ YES ☐ NO	Does home or work have known mold issues? ☐ YES ☐ NO

Are you aware of any toxic exposures in your past? _____

How many hours of "screen time" do you have each day (TV, computer, smart phones, tablets): _____

Have you traveled outside the US? When and where? _____

Military veterans: when and where did you serve? _____

SEXUAL HISTORY		
Currently sexually active? ☐ YES ☐ NO	**In the past?** ☐ YES ☐ NO	**With:** ☐ men ☐ women ☐ both
Types of intercourse: ☐ vaginal ☐ anal ☐ oral	**History of STDs?** ☐ YES ☐ NO If so, which?	
Method of contraception used:		
Level of sexual desire: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = highest		
Any sexual concerns? ☐ YES ☐ NO	**Any fertility concerns?** ☐ YES ☐ NO	

men's health	
Date of last prostate exam:	Any prostate or urinary concerns?
History of: ☐ hernia ☐ testicular pain ☐ testicular mass ☐ testicular torsion ☐ undescended testes as a child	

women's health				
Date of last menstrual period:		Age at first menses:		Age at menopause:
Length of menses (# days of bleeding):		Length of cycle (# days between):		
PMS symptoms (ex. mood swings, bloating):				
Menstrual symptoms (ex. pain, cramping):				
Date of last PAP smear:		Have you ever had an abnormal PAP? ☐ YES ☐ NO		
History of frequent vaginal infections? ☐ YES ☐ NO		Pain with intercourse? ☐ YES ☐ NO		
Number of:	pregnancies	births	miscarriages	abortions
Date of last mammogram:		Any concerns regarding breasts?		
Menopausal symptoms (ex. hot flashes):				

REVIEW OF SYSTEMS

Y = yes, current issue P = issue in the past N = never had this problem

GENERAL

height _____
current weight _____
maximum weight _____
(when?) _____
blood type _____

SKIN

acne ☐ Y ☐ P ☐ N
eczema or rashes ☐ Y ☐ P ☐ N
moles or lesions ☐ Y ☐ P ☐ N

HEAD

tension headaches ☐ Y ☐ P ☐ N
migraines ☐ Y ☐ P ☐ N
head injury ☐ Y ☐ P ☐ N

EYES

last eye exam _____
change in vision ☐ Y ☐ P ☐ N
double vision ☐ Y ☐ P ☐ N
eye pain ☐ Y ☐ P ☐ N
dry eyes ☐ Y ☐ P ☐ N
cataracts ☐ Y ☐ P ☐ N
glaucoma ☐ Y ☐ P ☐ N

EARS

impaired hearing ☐ Y ☐ P ☐ N
ringing (tinnitus) ☐ Y ☐ P ☐ N
ear pain ☐ Y ☐ P ☐ N
frequent infections ☐ Y ☐ P ☐ N

NOSE AND SINUSES

hay fever ☐ Y ☐ P ☐ N
congestion ☐ Y ☐ P ☐ N
nosebleeds ☐ Y ☐ P ☐ N
sinus infection ☐ Y ☐ P ☐ N

MOUTH AND THROAT

last dental exam _____
cavities ☐ Y ☐ P ☐ N
gum disease ☐ Y ☐ P ☐ N
mouth/tongue pain ☐ Y ☐ P ☐ N
sore throat ☐ Y ☐ P ☐ N
hoarseness ☐ Y ☐ P ☐ N
difficulty swallowing ☐ Y ☐ P ☐ N

NECK

pain or stiffness ☐ Y ☐ P ☐ N
swollen glands ☐ Y ☐ P ☐ N

RESPIRATORY

cough ☐ Y ☐ P ☐ N
wheezing ☐ Y ☐ P ☐ N
shortness of breath ☐ Y ☐ P ☐ N
asthma or COPD ☐ Y ☐ P ☐ N
pneumonia ☐ Y ☐ P ☐ N

CARDIOVASCULAR

last EKG _____
chest pain/angina ☐ Y ☐ P ☐ N
high blood pressure ☐ Y ☐ P ☐ N
heart palpitations ☐ Y ☐ P ☐ N
heart murmur ☐ Y ☐ P ☐ N
anemia ☐ Y ☐ P ☐ N
easy bruising ☐ Y ☐ P ☐ N
blood clots ☐ Y ☐ P ☐ N
varicose veins ☐ Y ☐ P ☐ N

ENDOCRINE

heat intolerance ☐ Y ☐ P ☐ N
cold intolerance ☐ Y ☐ P ☐ N
hyperthyroidism ☐ Y ☐ P ☐ N
hypothyroidism ☐ Y ☐ P ☐ N
diabetes ☐ Y ☐ P ☐ N

GASTROINTESTINAL

abdominal pain ☐ Y ☐ P ☐ N
nausea or vomiting ☐ Y ☐ P ☐ N
heartburn ☐ Y ☐ P ☐ N
gas or bloating ☐ Y ☐ P ☐ N
constipation ☐ Y ☐ P ☐ N
diarrhea ☐ Y ☐ P ☐ N
blood in stool ☐ Y ☐ P ☐ N
hemorrhoids ☐ Y ☐ P ☐ N
bowel movements per day _____

URINARY

pain with urination ☐ Y ☐ P ☐ N
frequency ☐ Y ☐ P ☐ N
urgency ☐ Y ☐ P ☐ N
nocturia (at night) ☐ Y ☐ P ☐ N
incontinence ☐ Y ☐ P ☐ N
bladder infections ☐ Y ☐ P ☐ N
kidney stones ☐ Y ☐ P ☐ N

MUSCULOSKELETAL

last bone density test _____
osteoporosis ☐ Y ☐ P ☐ N
joint pain/stiffness ☐ Y ☐ P ☐ N
muscle pain/spasm ☐ Y ☐ P ☐ N
muscle weakness ☐ Y ☐ P ☐ N

NEUROLOGICAL

stroke ☐ Y ☐ P ☐ N
seizures ☐ Y ☐ P ☐ N
tremor ☐ Y ☐ P ☐ N
numbness/tingling ☐ Y ☐ P ☐ N
loss of taste/smell ☐ Y ☐ P ☐ N
loss of memory ☐ Y ☐ P ☐ N
loss of balance ☐ Y ☐ P ☐ N
dizziness ☐ Y ☐ P ☐ N
fainting ☐ Y ☐ P ☐ N

Is there anything else you think we should know before the first visit? _____

_____

_____

_____

Thank you! We appreciate your time and attention to detail – and we look forward to working with you!

Please submit this form no later than 24 hours before the first appointment. Fax to 971-248-2096 or ask for a patient portal account.