willamette integrative health

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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**	**Blood type**
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	DOB	
Insured's address (if different from patient)			
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 voluntarily authorize the provision of health care services including examination, diagnostic tests and procedures, and medical treatment by Dr. Elizabeth C. Sedlak at Willamette Integrative Health. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care. I understand that I have the right to make decisions concerning my health care, including the right to refuse treatment.

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**

Please list your top health concerns:

1. _____
2. _____
3. _____

What are your expectations for our first visit? _____

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

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 (include year): _____

Major illnesses: _____

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

Adult vaccines: last TDaP (date): _____ ☐ pneumococcal ☐ shingles ☐ hepatitis B ☐ travel: _____

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

Do your religious beliefs impact your healthcare decisions? _____

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

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

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

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: ☐ never ☐ former ☐ current smoker packs per day ___ # years ___ trying to quit? ☐ YES ☐ NO

Other substance use: _____

Exercise and fitness: _____

Relaxation and hobbies: _____

sleep and energy	
Average hours sleep per night:	Do you wake refreshed? ☐ always ☐ usually ☐ rarely ☐ never
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:

SEXUAL HISTORY		
Currently sexually active? ☐ YES ☐ NO	**In the past?** ☐ YES ☐ NO	**With:** ☐ men ☐ women ☐ both
Method of contraception used:	**History of STDs?** ☐ YES ☐ NO If so, which?	
Any sexual/libido concerns? ☐ YES ☐ NO	**Any fertility concerns?** ☐ YES ☐ NO	

women's health				
Date of last menstrual period:		Age at first menses:		Age at menopause:
Length of menses (# days of bleeding):		Length of menstrual cycle:		
PMS or menstrual symptoms (mood swings, bloating, 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 _____

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 _____
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
seasonal allergies ☐ 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
swollen glands ☐ Y ☐ P ☐ N
hoarseness ☐ 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
COVID-19 ☐ 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
bloody/black stool ☐ Y ☐ P ☐ N
bowel movements per day _____

URINARY
pain with urination ☐ Y ☐ P ☐ N
frequency ☐ Y ☐ P ☐ N
urgency ☐ 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/fainting ☐ Y ☐ P ☐ N