



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

PATIENT INFORMATION					
<b>Patient name</b>	last	first	middle initial		
<b>Date of birth</b>	<b>Age</b>	<b>Sex</b>	<b>Pronouns</b>	<b>Blood type</b>	
<b>Mailing address</b>					
<b>City, State, Zip</b>			<b>Email</b>		
<b>Telephone</b>	cell	home	<input type="checkbox"/> voicemail ok <input type="checkbox"/> text ok		
<b>Race</b>	<input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White		<b>Ethnicity</b>	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
<b>Emergency contact</b>		relationship	phone		
How did you hear about our practice?					

INSURANCE INFORMATION			
<input type="checkbox"/> I will pay in full at time of service.		<input type="checkbox"/> 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
<b>ASSIGNMENT OF BENEFITS (FOR INSURANCE BILLING)</b>			<b>initials</b> _____
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		
<b>MEDICAL CONSENT</b>		<b>initials</b> _____
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.		
<b>FINANCIAL POLICY</b>		<b>initials</b> _____
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.		
<b>HIPAA PRIVACY POLICY and COMMUNICATIONS POLICY</b>		<b>initials</b> _____
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 <a href="http://willametteintegrative.com">http://willametteintegrative.com</a> under "Clinic Policies" – or please ask for a paper copy in the office).		
<b>I have read and fully understand all of the information above as conditions of my registration.</b>		
_____	_____	_____
<b>name of patient</b> (please print)	<b>signature</b> of patient or guardian	<b>date</b>

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	
<b>Are you</b> <input type="checkbox"/> single <input type="checkbox"/> dating <input type="checkbox"/> in a partnership <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed	
<b>Living with</b> <input type="checkbox"/> alone <input type="checkbox"/> spouse/partner <input type="checkbox"/> parents <input type="checkbox"/> children <input type="checkbox"/> relatives <input type="checkbox"/> friends <input type="checkbox"/> other	
<b>Employment</b> <input type="checkbox"/> employed full-time <input type="checkbox"/> employed part-time <input type="checkbox"/> student <input type="checkbox"/> unemployed <input type="checkbox"/> retired	
<b>Occupation</b>	<b>Employer / School</b>

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? <input type="checkbox"/> always <input type="checkbox"/> usually <input type="checkbox"/> rarely <input type="checkbox"/> never
Insomnia: <input type="checkbox"/> trouble falling asleep <input type="checkbox"/> trouble staying asleep    What keeps you awake?	
Average energy level throughout the day: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 = highest	
Best energy time of day:	Worst energy time of day:

SEXUAL HISTORY		
<b>Currently sexually active?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>With:</b> <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both
<b>Method of contraception used:</b>	<b>History of STDs?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO    If so, which?	
<b>Any sexual/libido concerns?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Any fertility concerns?</b> <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
History of frequent vaginal infections? <input type="checkbox"/> YES <input type="checkbox"/> NO			Pain with intercourse? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Number of:	pregnancies	births	miscarriages	abortions
Date of last mammogram:		Any concerns regarding breasts?		
Menopausal symptoms (ex. hot flashes):				

REVIEW OF SYSTEMS		
<i>Y = yes, current issue    P = issue in the past    N = never had this problem</i>		
<p><b>GENERAL</b></p> <p>height _____</p> <p>current weight _____</p> <p>maximum weight _____</p> <p><b>SKIN</b></p> <p>acne <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>eczema or rashes <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>moles or lesions <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>HEAD</b></p> <p>tension headaches <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>migraines <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>head injury <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>EYES</b></p> <p>last eye exam _____</p> <p>double vision <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>eye pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>dry eyes <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>cataracts <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>glaucoma <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>EARS</b></p> <p>impaired hearing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>ringing (tinnitus) <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>ear pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>frequent infections <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>NOSE AND SINUSES</b></p> <p>seasonal allergies <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>congestion <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>nosebleeds <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>sinus infection <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>	<p><b>MOUTH AND THROAT</b></p> <p>last dental exam _____</p> <p>cavities <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>gum disease <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>mouth/tongue pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>sore throat <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>swollen glands <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>hoarseness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>RESPIRATORY</b></p> <p>cough <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>wheezing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>asthma or COPD <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>pneumonia <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>COVID-19 <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>CARDIOVASCULAR</b></p> <p>last EKG _____</p> <p>chest pain/angina <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>high blood pressure <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>heart palpitations <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>heart murmur <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>anemia <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>easy bruising <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>blood clots <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>varicose veins <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>ENDOCRINE</b></p> <p>heat intolerance <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>cold intolerance <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>hyperthyroidism <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>hypothyroidism <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>diabetes <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>	<p><b>GASTROINTESTINAL</b></p> <p>abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>nausea or vomiting <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>heartburn <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>gas or bloating <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>constipation <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>diarrhea <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>bloody/black stool <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p># bowel movements per day _____</p> <p><b>URINARY</b></p> <p>pain with urination <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>frequency <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>urgency <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>incontinence <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>bladder infections <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>kidney stones <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>MUSCULOSKELETAL</b></p> <p>last bone density test _____</p> <p>osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>joint pain/stiffness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>muscle pain/spasm <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p><b>NEUROLOGICAL</b></p> <p>stroke <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>seizures <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>tremor <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>numbness/tingling <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>loss of taste/smell <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>loss of memory <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>loss of balance <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>dizziness/fainting <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>