OREGON
NATURAL MEDICINE
natural health.modern medicine

New Patient Intake

Full Name: _____

Gender: F M DOB:_____/_____/_____ Age: _____

Address:_____
_____

Home/Cell Phone:(_____)_____

Email Address: _____
May we correspond with you by email ? Y N

Relationship Status: ____ single ____married/partnered ____divorced/separated ____widowed

Emergency Contact:_____ Phone:_____

Employer: _____ Occupation: _____

Insurance Company: _____

How did you hear about our clinic? _____

Patient Medical History

Weight:_____ Height:_____

List your main reason(s) for coming in today:
_____
_____
_____

List any past hospitalizations, surgeries or major illnesses and approximate dates:
_____
_____
_____

Are you currently under the care of another physician? Y N
If yes, Physicians name: _____ Phone:_____
Reason for care: _____

Allergies-please list any medications, foods or environmental allergies & your reaction:
_____
_____
_____

Medications-list all prescription & over-the-counter medications & dosages you are currently taking:

_____

_____

_____

*bring Prescription Drug Bottles to your visit *

Supplements-list all herbal, homeopathic, hormonal, nutritional supplements you currently take, their dosage

_____

_____

_____

bring your bottles to appointment

Imaging/Diagnostic Studies-list any recent (ie: X-ray, MRI, Ultrasound, Thermography, Mammogram, DEXA scan)

_____

_____

_____

Female Gynecological History:

Date of Last Menstrual Period? _____

Last Annual/Pap exam?_____ Have you ever had an abnormal Pap? _____

# of Full Term Pregnancies? _____ # of Miscarriages? _____ # of Abortions?_____

Family History:

Father still living?: Y N If not, Age & Cause of death:_____

Mother still living?: Y N If not Age & Cause of death:_____

Check if any of your family members have had any of the following:

____ Alzheimers/Dementia	_____ Heart Disease	_____ Severe Depression
____ Breast Cancer	_____ High Blood Pressure	_____ Mental Illness
____ Cancer, other	_____ Bleeding Disorder	_____ Thyroid condition
____ Diabetes	_____ Genetic Disorder	_____ Autoimmune condition

List any other significant family medical history that is not listed above:

_____

_____

Review of Systems- check any of the symptoms that you are currently experiencing or experienced in the past 6 months:

General:	**Yes**	**Throat/Neck:**	**Yes**	**Eyes:**	**Yes**
Weight Loss/Gain		Frequent sore throat		History of Eye Injury	
More tired than usual		Voice Hoarseness		Blurred Vision	
Night Sweats		Change in Voice		Recent Change in Vision/vision loss	
Fevers		Swollen Lymph nodes		Excessive Tears/watery	
		Difficulty Swallowing		Dry Eyes	
Head:				Frequent Eye Infection/"pink-eye"	
Frequent Headaches/ Migraines		**Ears:**		Eye Twitching	
Dizziness/Vertigo		Frequent Ear Infections		Glaucoma	
History of Head Injury		Ringing in Ear/Tinnitis		Cataracts	

TMJ/ Jaw pain or clicking		Loss of hearing			
Nose/Sinuses:		**Gastrointestinal/Abdominal:**		**Breasts:**	
Loss of smell/Change in smell		Number of bowel movements per day:		Do you do Self breast exams?	
Frequent Sinus Infection/ Pain		Change in Bowel Habit		Breast pain/tenderness	
Hayfever/allergies		Constipation		Nipple Discharge	
Nasal Polyp		Diarrhea		Lump in Breast	
Frequent Nose Bleeds		Bloody Stool		Discoloration on breast	
		Black Stool		Currently Breastfeeding?	
Mouth/ Dental:		Hemorrhoids		History of Breast Surgery/biopsy	
Frequent Tooth pain/infection		Excessive Bloating & Gas		Breast Implants	
Bleeding Gums/ gingivitis		Intestinal Polyps		Breast Cancer	
Sores in mouth/tongue		Abdominal Pain/cramps			
Teeth Grinding		Nausea/Vomiting		**Female Reproductive/Genital:**	
		Liver Disease		Pain/cramps with Periods	
Respiratory/Chest:		Yellowing of skin or eyes		irregular periods	
Asthma				Insomnia/ trouble sleeping	
Shortness of Breath		**Urinary:**		Change in libido or sexual desire	
Frequent Cough		Increased urinary frequency		Night sweats	
Coughing up blood		Incontinence/urine leakage		Vaginal Discharge or odor	
Chest pain/ painful breathing		Waking at night to urinate		Vaginal Dryness	
		Bloody Urine		Frequent Infections: BV or yeast	
Cardiovascular/Heart:		Foul-smelling or cloudy urine		Pain with intercourse/sex	
Rapid heart beat		Frequent bladder infections		PMS	
Chest Pain/tightness in chest		History of Kidney Infections		History of Ovarian Cyst	
History of Heart Attack		History of Kidney Stones		History of Endometriosis	
High Blood Pressure				Are you currently sexually active?	
High Cholesterol/Triglycerides		**Male Reproductive/Genital:**		Are you taking Birth Control Pills?	
Sensation of missed beat/palpitation		History of Hernia		Do you have an IUD?	
History of Heart Murmur		Erectile Dysfunction/sexual difficulties		Other form of Contraception?	
History of Fainting		Change in libido or sexual desire		Difficulty Conceiving	
History of Rheumatic Fever		Testicular Pain or Mass		Have you had a Hysterectomy?	
Ankle Swelling		Discharge from penis		PCOS	
History of Blood Clots		Sores/lesions on penis/scrotum			
		History of sexually transmitted infection			
		History of Prostate Disease			
		Currently Sexually Active?			
		History of sexually			

		transmitted infection			
Endocrine:		**Musculoskeletal:**		**Skin:**	
Hair Loss		Chronic Aches/Pains		Rashes	
Brittle hair		History of Broken Bones		Acne, boils	
Increased thirst		Arthritis		Eczema	
Intolerance to cold/heat		Osteoporosis		Psoriasis	
Excessive Hunger/Thirst		Leg Cramps		Hives	
Excessive Urination		Restless Legs		Change in moles	
History of Diabetes Type I		Muscle Twitches?		Dry or Itchy skin	
History of Diabetes Type II		Low Back Pain/Sciatica		Oily Skin	
Hypothyroid		Stiffness upon waking		History of Skin Cancer	
Hyperthyroid/ Graves disease		General Stiffness		Excessive Sweating	
Goiter on Thyroid		Nerve Pain/ Neuropathy		Color Changes	
History of Thyroid Cancer		Weakness		Sores that won't heal	
Hashimoto's Disease		Numbness		Easy Bruising	
Cushings Disease		History-Back/neck surgery			
Addison's Disease		History-orthopedic surgery		**Nails:**	
Other Endocrine Condition?		Knee Pain/stiffness		Fungus	
		Shoulder pain/stiffness		Pitting	
Other:		Injury to back/neck		Discoloration	
History of any Cancer		Injury-legs/arms/shoulders		Break Easily	
History of Auto-Immune Condition		Carpal tunnel syndrome			
History of Eating Disorder		Tingling in hands/feet			
History of Abuse		Tendonitis			
		Plantar Fascitis/heel pain			

Please List any Conditions that were not addressed above:

Constitutional:

Your Temperature: _____ normal _____chilly _____ warm
Do you prefer: _____cold _____ heat
Perspiration: _____easily perspire _____ do not perspire easily
Favorite Foods: _____ Foods that disgust you: _____
Energy is best at : ___ morning(6-11am) ___afternoon(11-4pm) ___evening(5-9pm) ____night (after 10pm)
Fears: _____
Company: _____ usually want people around me _____ prefer be alone often _____ a bit of both
You would describe yourself as…_____

Habits/Lifestyle:

Typical Breakfast, Lunch and Dinner on weekday?
B: _____
L: _____
D: _____
Any special diet (Vegetarian, Vegan, Gluten-free, etc.) _____
Water:# of 10-12 ounce glasses daily: _____ Caffeine (coffee, tea, soda): # of cups per day: _____
Alcoholic Beverages per week ? _____ History of alcoholism? Y N
Tobacco Product use? _____ no, never ____ yes, currently ____yes, but I have quit
Recreation drugs? Y N Which ones? _____ History of drug addiction? Y N
Exercise: your current routine: _____
Sleep: number of hours on typical night? _____ Feel well rested upon waking in the morning? Y N

Hobbies:-please list? _____
Current stress level? Mild Moderate Severe Cause of your stress? _____

Informed Consent for Treatment

Consent to Treat:
I, _____ (patient's name), hereby voluntarily request and willingly consent to receive treatment, receive physical examinations and procedures, performing diagnostic procedures, ordering of diagnostic lab work and medical imaging including, but not limited to thermography, and receive diagnosis by the Physician at Oregon Natural Medicine, LLC. I understand that the Physicians will only be working within their scope of practice.

Acknowledgment of Risks:
I understand that Naturopathic Medicine practiced at Oregon Natural Medicine, LLC is generally considered safe, but may pose certain risks to me. These potential risks may include allergic reaction to supplements and/or pharmaceuticals prescribed to me, muscle soreness following a physical medicine procedure, redness and swelling at site of injection or venipuncture. I agree to contact the a staff member of Oregon Natural Medicine, LLC immediately if I believe any adverse reaction may be occurring due to a treatment that was recommended or performed at this clinic. I will inform my healthcare practitioner of any previous allergic reaction I have had to any pharmaceutical, nutritional supplement, herbal supplement, homeopathic supplement or topical medicine.

I understand that certain nutritional and herbal supplements may be harmful to pregnant women and/or their unborn child. I will inform my healthcare practitioner at Oregon Natural Medicine, LLC if/when I become pregnant, if there is a chance that I may be pregnant, or if I am lactating.

I understand that Naturopathic Medicine is generally very safe and effective, but I realize that there is no guarantee of cure for my medical condition.

Consent to bill Insurance:
I give authorization for Oregon Natural Medicine, LLC to bill my health insurance on my behalf. I authorize payment to be sent directly to Oregon Natural Medicine, LLC. I understand that any charges accrued on my behalf will ultimately be my responsibility to pay**,** even if my insurance company has been billed and denies payment. *Please note that we only directly bill for Motor Vehicle Accidents and certain limited health-plans.*

Hippa/Privacy Policy:
I understand that **my medical record will be kept private**. I understand that the Clinical and support staff at Oregon Natural Medicine, LLC will have access to my medical record. I acknowledge that my information will never be disclosed to anyone with out my consent, except in the case where it is mandated by state law. I understand that I have the right to view my medical chart. I understand that I may request a copy of my medical chart by paying the set fee for photocopying services. I understand that I may request to view the full 'Privacy Policy' per my request.

Signature:
I intend this form to cover my current condition(s), as well as any conditions that may arise in the future that I may seek treatment for at this clinic. By signing this form, I agree to the above statements.

Printed name of Patient: _____
Signature (Patient or legal guardian): _____ Date: _____

***Optional:**

I understand that the Health Practitioners at Oregon Natural Medicine, LLC are involved with teaching, writing and medical research. I authorize the use of my medical case in their **teaching, writing, or research**. I understand that all identifying information about me will be removed, I will be completely anonymous.

Optional: Please initial if you agree to this: _____

Office Policies

Thank you for choosing Oregon Natural Medicine for your healthcare. Please take a moment to read about our office policies. Understanding these policies will help us to best serve you!

Appointments: We have reserved your scheduled appointment time for you and ask that if you need to **cancel** that you need to give us **24 hours advance notice**. If you miss your appointment or cancel with less than 24 hours, we will **charge your account $50**. This fee will be waived for emergency situations.

Payment & Insurance: Payment in full is due at time of service. We will gladly provide you with a service summary for you to self-submit to your insurance company for potential reimbursement. One exception is Motor Vehicle Insurance, which we may bill directly for you.

Telephone: We are more than happy to have a brief phone conversation to answer your questions. If this phone conversation goes **beyond 10 minutes** or substitutes for an office visit (such as changes made to your treatment plan) you will be billed the same as our normal office visit rates.

Email: If you choose to email your doctor, please know that email is only intended for brief questions and to clarify treatment plans. Your doctor will typically respond within 1 business day. We do not have a secured server for email, therefore it does have the risk of mal-use from an outside party ("hacked"); it is your choice to use email or phone for communication with your doctor.

Supplements: We appreciate your supporting local business by purchasing your high quality nutritional, herbal and homeopathic supplements at Oregon Natural Medicine. We strive to keep our prices affordable. Please note that we are **unable to refund** any purchased product once it has left our premise. Please call ahead to pick-up a refill for your supplements, so that we can confirm this item is in-stock.

Prescriptions & Refills: We require patients to **have a follow-up office visit** before we will **refill** prescription drugs. This allows us to make changes to the dosage or treatment as necessary. No new prescription will be given over a phone consult, the patient must be seen in-office first.

Emergency Care: We do **not** provide emergency medical care or after-hours treatment at Oregon Natural Medicine. If you are concerned that you may be experiencing a medical emergency, **please call 911**. If you are not experiencing a medical emergency, you may leave a voice message on our office phone 503-946-8700 and we will return your call the next business day.

By signing this form, you are agreeing to the Office Policies at Oregon Natural Medicine, LLC.

Print Patient's Name:_____

Signature (Patient or Legal Guardian): _____

Date: _____