Patient Intake Form

Please fill out as thoroughly as possible and bring to your first visit.

PATIENT INFORMATION

Name_____ **DOB**_____ **Age**_____ **Sex:** ☐ Male ☐ Female

Address_____ **City/Zip**_____

Telephone: Home_____ **Cell**_____ **Work**_____

At what numbers may we leave health-related messages? ☐ Home ☐ Cell ☐ Work

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Domestic Partnership ☐ Civil Union ☐ Other

Number of children & their names and age(s)_____

Occupation_____ **Employer**_____

Emergency contact_____ **Relation**_____ **Telephone**_____

Insurance Primary_____ **Secondary**_____

How did you learn about the clinic? _____

Email address for appointment reminders_____

CURRENT HEALTH CONCERNS

Please list current concerns in order of priority:

Condition or Concern (in order of importance)	Onset	Diagnosed by physician?

What is your main goal for today? _____

Are you currently being treated by any physician(s)? ☐ Yes ☐ No

Physician_____ **Condition(s) being treated**_____

Physician_____ **Condition(s) being treated**_____

Physician_____ **Condition(s) being treated**_____

Have you seen a naturopathic doctor before? ☐ Yes ☐ No **If yes, who?** _____

Prescription medications_____

_____

_____

Non-prescription medications (herbs, vitamins, minerals, etc.)_____

_____

_____

_____

PERSONAL AND FAMILY MEDICAL HISTORY

Personal & Family Medical History

Please check those that apply to you or your close family members. Indicate "self" in the line provided if you have personal history with a condition. If a condition has occurred in your family, indicate the family member's relationship to you (including parents, grandparents, siblings, children and current spouse).

- ☐ AIDS/HIV _____
- ☐ Alcoholism _____
- ☐ Anemia _____
- ☐ Anorexia _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ ↑ BP _____
- ☐ Bulimia _____
- ☐ Cancer--Type(s): _____
- ☐ ↑ Cholesterol _____
- ☐ Colitis _____
- ☐ Dementia _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Drug addiction _____
- ☐ Hypoglycemia _____
- ☐ Gout _____
- ☐ Kidney Dz _____
- ☐ Liver Dz _____
- ☐ Mental Illness _____
- ☐ Migraines _____
- ☐ Obesity _____
- ☐ Seizures _____
- ☐ Sex abuse _____
- ☐ STD—Type(s): _____
- ☐ Stroke _____
- ☐ Suicide _____
- ☐ Thyroid Dz _____
- ☐ Tuberculosis _____
- ☐ Ulcer _____
- ☐ Other _____

Review of Systems

Please indicate the conditions or symptoms you've personally experienced with either a (C) for current conditions (those that you have experienced within the past 2 weeks) or a (P) for conditions you have had in the past (beyond 2 weeks). Otherwise, mark with an (N) to indicate conditions you have never experienced.

General

Weight_____ Height_____

Weight 1 year ago_____

Energy scale 1-10 (10 best)_____

Skin

	C	P	N
Rash	C	P	N
Acne	C	P	N
Eczema	C	P	N
Dry skin	C	P	N
Night sweats	C	P	N
Hot flashes	C	P	N
Hair loss	C	P	N

Head

	C	P	N
Headache	C	P	N
Head injury	C	P	N
Dizziness	C	P	N

Neck

	C	P	N
Lumps	C	P	N
Swollen lymph nodes	C	P	N
Goiter	C	P	N
Pain or stiffness	C	P	N

Mouth & Throat

	C	P	N
Frequent sore throat	C	P	N
Sore tongue	C	P	N
Gum problems	C	P	N
Hoarseness	C	P	N
Scratchy throat	C	P	N

Eyes

	C	P	N
Impaired vision	C	P	N
Glasses or contacts	C	P	N
Eye pain	C	P	N
Tearing	C	P	N
Dryness	C	P	N
Double vision	C	P	N
Glaucoma	C	P	N
Cataracts	C	P	N

Ears

	C	P	N
Impaired hearing	C	P	N
Ringing	C	P	N
Ear pain	C	P	N

Nose & Sinuses

	C	P	N
Frequent colds	C	P	N
Nose bleeds	C	P	N
Sinus congestion	C	P	N
Sinus infection	C	P	N

Respiratory

	C	P	N
Cough (wet or dry?)	C	P	N
Spit/cough up blood	C	P	N
Wheezing	C	P	N
Bronchitis	C	P	N
Pneumonia	C	P	N
Pleurisy	C	P	N
Emphysema	C	P	N

Difficulty breathing	C	P	N
Pain on breathing	C	P	N

Cardiovascular

Angina	C	P	N
Murmurs	C	P	N
Rheumatic fever	C	P	N
Chest pain	C	P	N
Ankle swelling	C	P	N
Palpitations, fluttering	C	P	N
Varicose veins	C	P	N
Cold hands/feet	C	P	N

Musculoskeletal

Joint pain/stiffness	C	P	N
Broken bones	C	P	N
Muscle spasm/cramps	C	P	N
Muscle weakness	C	P	N

Endocrine

Hyperthyroid	C	P	N
Hypothyroid	C	P	N
Diabetes	C	P	N

Neurologic

Fainting	C	P	N
Seizures	C	P	N
Paralysis	C	P	N
Numbness or tingling	C	P	N
Memory difficulties	C	P	N
Brain fog	C	P	N

Emotional

Irritability	C	P	N
Depression	C	P	N
Anxiety	C	P	N

Gastrointestinal

Difficulty swallowing	C	P	N
Heartburn	C	P	N
Change in thirst	C	P	N
Change in appetite	C	P	N
Nausea	C	P	N
Vomiting	C	P	N
Blood in stool	C	P	N
Belching/burping	C	P	N
Gas/bloating	C	P	N
Ulcer	C	P	N
Hemorrhoids	C	P	N

Bowel movements per day_____

Urinary

Pain on urination	C	P	N
↑ Urination frequency	C	P	N
↑ Nighttime urination	C	P	N
Inability to hold urine	C	P	N
Frequent infections	C	P	N
Kidney stones	C	P	N

Female Reproductive

Sexually active	C	P	N
Low libido	C	P	N
Sexual difficulties	C	P	N
Pain with intercourse	C	P	N
Vaginal dryness	C	P	N
Vaginal itch	C	P	N
Nipple discharge	C	P	N

PMS/painful menses	C	P	N
Excessive flow	C	P	N
Scanty flow	C	P	N
Difficulty conceiving	C	P	N
Current birth control?		Y	N

Type_____

Pregnancies_____

Live births_____

Miscarriages_____

Irregular cycles	C	P	N

Current cycle length _____days

Length of bleeding _____days

Last pelvic exam on_____

Hysterectomy?		Y	N

Menopause since_____

Male Reproductive

Hernia	C	P	N
Testicular mass	C	P	N
Testicular pain	C	P	N
Sexually active?	C	P	N
Low libido	C	P	N
Sexual difficulties	C	P	N
Pain with intercourse	C	P	N
Prostate disease	C	P	N

Last prostate exam on_____

Miscellaneous

Anemia	C	P	N
Easy bruising	C	P	N
Bone loss	C	P	N
Chemical sensitivities	C	P	N
Cravings	C	P	N

All major drug and food allergies_____

Hospitalizations, surgeries, and major illnesses (include date)_____

_____

_____

Childhood illnesses—Please check all those you've experienced:

☐ Scarlet fever ☐ Strep throat ☐ Pneumonia ☐ Mumps ☐ Measles ☐ Rheumatic fever ☐ Rubella ☐ Chicken pox

Immunization history—Please check all those you've received:

☐ Poliovirus ☐ DTaP ☐ MMR ☐ HiB ☐ HPV ☐ Hep A ☐ Hep B

☐ Rotavirus ☐ Pneumococcal ☐ Influenza ☐ Varicella ☐ Meningococcal

Tobacco use? ☐ Yes ☐ No Type_____ **Frequency**_____

Alcohol use? ☐ Yes ☐ No Type_____ **Frequency**_____

Recreational drug use? ☐ Yes ☐ No Type_____ **Frequency**_____

Current exercise routine? ☐ Yes ☐ No Type_____ **Frequency**_____

Dietary restrictions? ☐ Yes ☐ No **Please describe**_____

Typical breakfast_____

Typical lunch_____

Typical dinner_____

Typical snacks_____

Daily water intake_____ **Other beverages**_____

Hours of sleep per night_____ **Trouble falling asleep?** ☐ Yes ☐ No **Trouble staying asleep?** ☐ Yes ☐ No

Date of last physical exam_____ **Date of last blood tests**_____

PEDIATRIC PATIENTS ONLY

Nickname_____ **Mother's name**_____ **Father's name**_____

Term: ☐ **Early** ☐ **Full** ☐ **Late** **Birth weight**_____**lbs.**_____**oz.** **Length of labor**_____

Pregnancy complications? ☐ Yes ☐ No **Please describe**_____

Labor complications? ☐ Yes ☐ No **Please describe**_____

Breastfed? ☐ Yes ☐ No **How long?**_____ **Formula fed?** ☐ Yes ☐ No **Milk / soy / other**_____

Age your child began: Solid foods_____ **Sitting**_____ **Crawling**_____ **Walking**_____ **First words**_____

 # Urinations per day_____ **# Bowel movements per day**_____ **Blood or mucous in stool?** ☐ Yes ☐ No

Please indicate if your child has had any of the following:

Birth defects	Y N	Cries easily	C P N	Nose bleeds	C P N
Birth injuries	Y N	Diarrhea	C P N	Rash	C P N
Colic	C P N	Fever	C P N	Seizures	C P N
Constipation	C P N	Jaundice	C P N	Teeth problems	C P N
Cough	C P N	Nightmares	C P N	Unusual fears	C P N

STATEMENT OF FINANCIAL RESPONSIBILITY

Payment Policy

I understand that payment is expected in full at time of service and that accepted forms of payment include cash, personal checks, Visa and Mastercard. I am aware that NSF checks will be subjected to a $25 fee. If Dr. Wais is not contracted with your insurance you can, however, request an invoice at the end of each visit, which you may then submit to your insurance company for reimbursement. I understand that Absolute Wellness Clinic does not guarantee reimbursement by my insurance company, and that it is my responsibility to determine my coverage for naturopathic care. I understand that it is not the responsibility of Absolute Wellness Clinic to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

I understand that I may request the fees for various procedures before they occur in order to include that information in my healthcare decision-making process. I understand that my practitioner may offer telephone consultations at an additional fee, which I will be made aware of in advance.

Cancellation Policy

I am aware that Absolute Wellness Clinic requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. I understand that missed appointments without notification may be charged a late cancellation fee of $50, and cancellations with less than 24 hours notice may be billed 50% of the visit fee.

Patient/Guardian signature_____ **Date**_____

Absolute Wellness Clinic
465 Rainier Blvd. N. Sutie A
Issaquah, WA 98027
Phone: 425-392-5321 Fax: 425-837-3785

CONSENT FOR TREATMENT

General Information: Absolute Wellness Clinic, PS, (AWC) is a naturopathic medical clinic that integrates a number of medical treatment modalities. Due to the diversity of modalities offered at AWC, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Allopathic Medicine, Physical Medicine, Therapeutic Exercise, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the procedures described below in order to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures (Includes, but is not limited to, venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments.)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Herbs/Natural Medicines (Includes the prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may be used.)

Dietary Advice and Therapeutic Nutrition (Includes the use of foods, diet plans or nutritional supplements for treatment and may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (Includes the use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (Includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies.)

Pharmaceutical Medication: Your physician may, at times, prescribe prescription medication for your care, which can not include scheduled drugs, with the exception of testosterone and codeine.

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant or Breastfeeding Women: All female patients must alert the doctor if they know or suspect that they are pregnant since some of the therapies used could present a risk to the pregnancy or to the baby during breastfeeding.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by AWC or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Relationship/Representative's Authority	Date

Acknowledgement of Privacy Practices

Lindsay A Wais, N.D.
465 Rainier Blvd. N. Suite A
Issaquah, WA 98027

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my Naturopath's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my Naturopath has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *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 health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

I authorize the Absolute Wellness Clinic to release medical information, test and procedure results, appointment information, or other health information to the following individuals:

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

By signing below I also indicate that I understand that any contact made with Dr. Wais through email is not a secure form of communication and I release Dr. Wais of responsibility concerning any problems that may occur through email communications.

Signature: _____ Date: _____

Prescription Policy & Pharmacy Information

The Absolute Wellness Clinic requires a notice of **three business days** to fill all **new** prescriptions and prescription refill requests.

If a request is not made **at least three business days** in advance there is no guarantee that the prescription will be filled by a specific date or time. We ask you to be mindful of when your prescriptions are running low and to take the appropriate actions to get refills taken care of in a respectful time manner. Also, while contacting us is helpful in getting prescriptions filled, we require that you contact your pharmacy as well and have them fax us a prescription refill request. Requests can be faxed to 425.837.3785.

By signing below you indicate that you understand our Prescription Policy and will adhere to the required actions. Furthermore, you accept that The Absolute Wellness Clinic is not responsible for prescriptions that are not filled as needed if the three business day notice was not provided.

_____

Signature Date

Please provide us with the name and city of your preferred pharmacy where we may send your prescriptions:

Pharmacy name _____

Pharmacy city/zip _____

Authorization for Release of Health Information

Patient Name_____ **DOB**_____ **Telephone**_____

Address_____ **City/Zip**_____

Please release information FROM:

Name_____

Facility_____

Address_____

_____

Phone_____ Fax_____

Please release information TO:

Lindsay Wais, ND

Absolute Wellness Clinic

465 Rainier Blvd. N. Suite A

Issaquah, WA 98027

Phone: (425)392-5321 **Fax: (425)837-3785**

Please specify the health information you authorize to be released:

- ☐ Labs ☐ All ☐ Specify _____
- ☐ Imaging Reports ☐ All ☐ Specify _____
- ☐ Chartnotes ☐ All ☐ Specify _____
- ☐ Other_____

The following information will not be released unless you specifically authorize it by initialing below:

_____ I authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.
_____ I authorize the release of HIV/AIDS test results.
_____ I authorize the release of genetic testing information.

Absolute Wellness Clinic and many other health care institutions are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it might no longer be protected by state or federal confidentiality laws.

Unless otherwise revoked, this authorization expires 6 months after the date of signing this form. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your guardian, and mailed or faxed to Absolute Wellness Clinic. The revocation will take effect when Absolute Wellness Clinic receives it, except to the extent Absolute Wellness Clinic or others have already relied upon it. You are entitled to receive a copy of this authorization.

_____ (initial) ***I acknowledge that I have read and understand the above statement.***

_____
Patient (or Parent/Guardian)

_____
If parent/guardian, print patient's name

_____
Print Name

_____
Relationship to Patient

_____
Date