Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? O No O Yes (specify): O Home O Work O Cell

Email address: _____ O Check here if you would prefer not to receive our email newsletter.

Date of Birth: _____ Sex: _____ Other names that records may be kept under: _____

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (_____)_____ O Home O Work O Cell

How did you hear about us? O Newspaper Ad O News Story O Mailer/Flyer O Website O Workshop/Event
O Friend/Family O Yellow Pages O Medical Referral O Other: _____

The following information is optional and requested for potential research information

Marital Status *(circle one):* Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____
Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Missed Appointment policy: We request 24 notice if unable to keep an appointment. Stevens Naturopathic Center retains the right to bill you for full cost of appointments if not cancelled before 24 hours. Visits cancelled less than 24 hours may be billed at half price.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Stevens Naturopathic Center is required to provide you with a copy of our Notice of Privacy Practices upon request. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call (509) 590-1343.

I hereby acknowledge that I may receive a copy of Stevens Naturopathic Center's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that they have made a good faith effort to obtain my acknowledgement.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority

(version 9-22-10)

CONSENT FOR TREATMENT

I hereby authorize the practitioners of Stevens Naturopathic Center to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but 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 (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 cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue and Manipulation (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, and hydrotherapies.)
Hydrotherapy (includes the use of water as a bath, hot or cold pack, or as part of colon hydrotherapy)

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 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. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

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 any practitioner of Stevens Naturopathic Center. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

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

Stevens Naturopathic Center

21950 E. Country Vista Dr., Suite 600
Liberty Lake, WA 99019
(509) 590-1343 Fax (866) 774-8216

Adult Health History – First Office Visit

Today's Date:_____ Name:_____
Gender:_____ Date of Birth:_____
Occupation:_____
Marital Status (please circle): Single Married/Partnered Divorced Widowed
Do you have children?_____Ages:_____

Please list your present health concerns in order of importance:
1) _____Date of onset:_____

2) _____Date of onset:_____

3) _____Date of onset:_____

4) _____Date of onset:_____

5) _____Date of onset:_____

Is there any other information re: your health which you would like to add?
_____
_____
_____

What other health care are you presently receiving?_____
_____
_____
_____
When was your last physical exam? _____Name of Doctor_____
Have you been vaccinated?_____

Please list any surgeries or hospitalizations including
dates:_____
_____
_____

Please briefly describe all serious accidents, severe injuries, head injuries, and broken bones including dates:

_____

_____

_____

Please list prescription medications that you are currently taking, with dosages:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Others:

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Others:

Please list any known allergies (food, chemical, environmental, pharmaceutical):

_____

_____

_____

Are any of them life-threatening?_____If so, which one(s)?_____

Lifestyle

Smoking (type and amount per day)?_____
If former smoker, date quit_____

Alcohol (type and amount per week)?_____
If former drinker, date quit_____

Caffeine (type and amount per week)?_____
Recreational drugs (type and amount per week)? _____

How much sleep do you get per night?_____
Quality of sleep?_____

Exercise (type and amount per week)? _____

Stress level? (check one) _____ None _____ Mild _____ Moderate _____Severe
Do you enjoy your work?_____

Do you follow any particular diet regimens or restrictions? If yes, please describe:_____

Describe your food habits in a typical day:
Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you always wear a seat belt while in a vehicle?_____

Do you always wear a helmet while on a bicycle or motorcycle?_____

Are you sexually involved with _____ men _____ women _____ both? Do you always practice safe sex?_____

Primary emotional state/mood?_____

Family Health History

Please mark with the appropriate letter if any of your blood relatives have had any of the following conditions:
(M=mother, F=father, S=sibling, G=grandparent, C=child)

_____ Allergies	_____ Hayfever
_____ Anemia	_____ Heart Disease
_____ Arthritis	_____ Hepatitis
_____ Asthma	_____ High blood pressure
_____ Cancer	_____ High cholesterol

If so what type:_____

_____ Depression	_____Kidney Disease
_____ Diabetes	_____ Migraines
_____ Drug or alcohol problem	_____ Obesity
_____ Eczema	_____ Stroke/Heart Attack
_____ Epilepsy	_____ Skin disorders - Type:_____
_____ Glaucoma	_____ Syphilis
_____ Gonorrhea	_____ Thyroid Disease
_____ Gout	_____ Tuberculosis

_____Other:_____

Past Medical History

Do you know of any chemical exposure, past or present, to any of the following toxic substances:

____Mercury ____Lead ____Arsenic ____Herbicides/Pesticides
____Formaldehyde _____Other:_____

Please indicate with a C for current or P for past in the spaces for conditions that you have been diagnosed:

____ADD/ADHD	____Allergies	____Anemia
____Anxiety	____Arthritis	____Asthma
____Back/Neck Pain	____Bladder infections	____Bleeding disorders
____Bronchitis	____Cancer – Type:_____	
____Chickenpox	____Chronic Fatigue Syndrome	
____Crohn's disease	____Depression	____Diabetes Circle: Type I or II
_____ Eczema	____Epilepsy	____Fibromyalgia
____Glaucoma	____Heart disease	____Hepatitis
____Hernia	____High blood pressure	____High cholesterol
____Hives	____HIV/AIDS	____Infectious Mono
____IBS	____Kidney disease	____Low blood pressure
____Lupus	____Measles	____Mitral valve prolapse
____Migraines	____Mumps	____Polio
____Pneumonia	____Rheumatic fever	____Scarlet fever
____Schizophrenia	____Strep throat	____STD's
____Stroke	____Thyroid disease	____Tuberculosis
____Ulcer	____Ulcerative colitis	____Whooping cough

____Other disease (please list):_____

Thank you for taking the time to fill out this form to the best of your ability. While these forms can be tedious, they provide valuable information to help your doctor to treat you better