COLVILLE NATUROPATHIC CLINIC P.S.

Health History Questionnaire

Patient Name_____ Today's Date_____

Date of Birth_____ Age_____ (please circle) Sex **M / F** Blood Type **A / B / AB / O**

Address (mailing) _____

City _____ State _____ Zip Code _____

Telephone (home) _____ (Work) _____ (Cell) _____

Education_____ Occupation _____

Marital Status:

Married _____ Separated_____ Divorced _____ Widowed _____ Single _____

Live With:

Spouse _____ Children _____ Parents _____ Relatives _____ Alone _____

Naturopathic health care and preventative medicine are best achieved when the physician has a greater understanding of the patient physically, mentally, emotionally, and spiritually. Please complete this questionnaire as thoroughly as possible. **Please Print** all information and **mark anything you don't understand with a question mark (?)**.

When and where did you last receive medical or health care? _____

_____

What was the reason for your last medical/health care visit? _____

_____

How did you hear about our Clinic? _____

What are your most important health problems? Please list any and all concerns in order of importance.

_____

_____

_____

_____

_____

_____

_____

_____

Family History

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child(ren)
Age (if living)	_____	_____	_____	_____	_____	_____
Health G=good P=poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hay Fever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Age at death (if applicable)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=yes or N=no

Childhood Illnesses

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N
Mumps Y N Measles Y N German Measles Y N
Other _____

Immunizations

Polio Y N Pertussis Y N Tetanus (not antitoxin) Y N
Diphtheria Y N Measles/Mumps/Rubella Y N Other _____

Hospitalization and Surgery

Please list hospitalizations and surgeries you have had: _____

_____

_____

X-rays and Special Studies

X-rays, CAT scans, or MRI you have had: _____

_____

Allergies

Please list all food, drug, and other allergies: _____

_____

Medications

Please list **all** prescription medications, over the counter medications, vitamins, herbs, and/or other supplements you are taking: _____

_____

REVIEW OF SYSTEMS

For each of the following please circle **Y, P, or N**

Y= condition you have now **P**= a condition you have had in the past **N**=Never had

General

Fatigue Y P N

Height _____

Weight _____

Weight 1 year ago _____

Maximum weight _____

When _____

Skin

Rashes..... Y P N

Eczema.....Y P N

Hives.....Y P N

Acne.....Y P N

Boils.....Y P N

Itching.....Y P N

Color change.....Y P N

Lumps.....Y P N

Night Sweats.....Y P N

Head

Headaches.....Y P N

Head injury.....Y P N

Eyes

Impaired vision.....Y P N

Glasses or contacts.....Y P N

Eye Pain.....Y P N

Tearing or dryness.....Y P N

Double vision.....Y P N

Glaucoma.....Y P N

Cataracts.....Y P N

Ears

Impaired Hearing.....Y P N

Ringing.....Y P N

Earache.....Y P N

Dizziness.....Y P N

Nose and Sinuses

Frequent Colds.....Y P N

Nose Bleeds.....Y P N

Stuffiness.....Y P N

Hay Fever.....Y P N

Sinus Problems.....Y P N

Mouth and Throat

Frequent sore throat.....Y P N

Sore tongue.....Y P N

Gum problems.....Y P N

Hoarseness.....Y P N

Dental cavities.....Y P N

Neck

Lumps.....Y P N

Swollen glands.....Y P N

Goiter.....Y P N

Pain or stiffness.....Y P N

Respiratory

Cough.....Y P N

Sputum.....Y P N

Spitting up blood.....Y P N

Wheezing.....Y P N

Asthma.....Y P N

Bronchitis.....Y P N

Pneumonia.....Y P N

Pleurisy .....Y P N

Difficulty breathing.....Y P N

Pain w/breathing.....Y P N

Shortness of breath.....Y P N

Shortness of breath at night.....Y P N

Shortness of breath lying down.....Y P N

Tuberculosis.....Y P N

Cardiovascular

Heart disease.....Y P N

Angina.....Y P N

High blood pressure.....Y P N

Murmurs.....Y P N

Rheumatic fever.....Y P N

Chest pain.....Y P N

Swelling in ankles.....Y P N

Palpitations, flutters.....Y P N

Gastrointestinal

Trouble swallowing.....Y P N

Heartburn.....Y P N

Change in thirst.....Y P N

Change in appetite.....Y P N

Nausea.....Y P N

Vomiting.....Y P N

Vomiting blood.....Y P N

Blood in stool.....Y P N

Belching, passing gas.....Y P N

Jaundice (yellow skin) .....Y P N

Liver disease.....Y P N

Gall bladder disease.....Y P N

Ulcer.....Y P N

Hemorrhoids .....Y P N

Bowel movements: how often _____

Is this a change? _____

Urinary

Pain on urination.....Y P N
Increased frequency.....Y P N
Frequency at night.....Y P N
Inability to hold urine.....Y P N
Frequent infections.....Y P N
Kidney stones.....Y P N

Female Reproduction

Age menses began _____
Average # of Days _____
Length of cycle _____
Bleeding between cycles.....Y P N
Are Cycles regular.....Y P N
Painful Menses.....Y P N
Excessive flow.....Y P N
Menopausal symptoms.....Y P N
Are you Sexually Active_____
# of partners in last 12 months_____
Do you practice anal sex_____
Gender of partners (m/f/both) _____
Pain during intercourse.....Y P N
Sexual difficulties.....Y P N
STD/STI.....Y P N
Discharge or sores.....Y P N
Birth Control.....Y P N
What type/ How long? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages_____
Number of abortions _____
Difficulty conceiving .....Y P N
Planning a pregnancy in 6-12 months?_____
Last Pap_____
Any abnormalities?_____

Breast

Do you self-exam.....Y P N
Lumps.....Y P N
Pain /Tenderness.....Y P N
Nipple discharge.....Y P N
Last Mammogram_____
Any abnormalities_____
Last Thermography_____
Any abnormalities_____

Male Reproductive

Hernias.....Y P N
Testicular masses.....Y P N
Testicular pain.....Y P N
Prostate disease.....Y P N
Are you Sexually Active_____
# of partners in last 12 months_____
Do you practice anal sex_____
Gender of partners (m/f/both)_____
Sexual difficulties.....Y P N
STD/STI.....Y P N
Discharge or sores.....Y P N

Musculoskeletal

Joint pain or stiffness.....Y P N
Arthritis.....Y P N
Broken bones.....Y P N
Muscle spasms or cramps.....Y P N
Weakness.....Y P N

Peripheral Vascular

Deep leg pain.....Y P N
Cold hands/feet.....Y P N
Varicose veins.....Y P N
Thrombophlebitis.....Y P N

Neurological

Fainting.....Y P N
Seizures.....Y P N
Paralysis.....Y P N
Muscle Weakness.....Y P N
Numbness or tingling.....Y P N
Loss of memory.....Y P N

Emotional

Depression.....Y P N
Mood swings.....Y P N
Anxiety or nervousness.....Y P N
Tension.....Y P N

Endocrine

Hypothyroid.....Y P N
Heat/Cold intolerance.....Y P N
Excessive thirst.....Y P N
Excessive hunger.....Y P N

Blood

Anemia.....Y P N
Easy bleeding or bruising.....Y P N

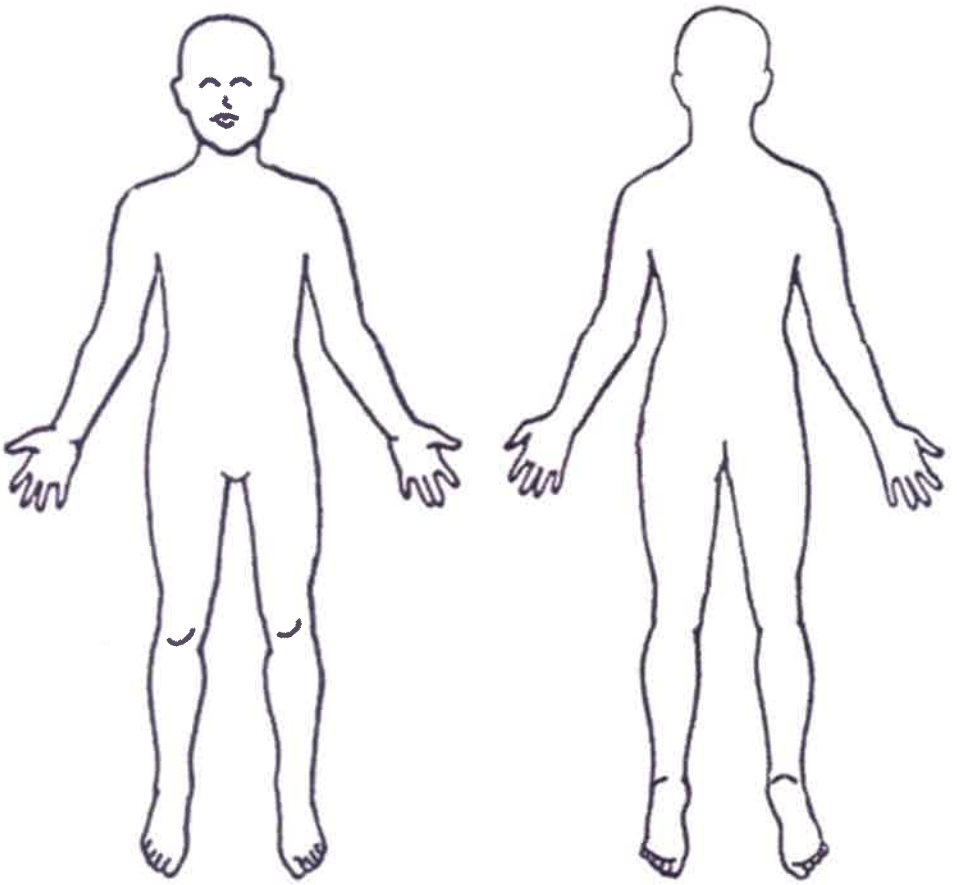
Habits

What are your main interests or hobbies?

_____
_____
_____
_____

Do you exercise?.....Y P N
What Kind(s)_____
_____
How often_____
Do you eat three meals daily.....Y P N
Food Cravings_____
Awaken rested.....Y P N
Sleep Well.....Y P N
Average 6-8 hours sleep.....Y P N
Enjoy your work.....Y P N
Spend time outside.....Y P N
Watch television.....Y P N
How many hours a day?_____
Read.....Y P N
How many hours a day?_____
Take vacations.....Y P N
Treated for drug dependence.....Y P N
Use recreational drugs.....Y P N
Use alcoholic beverages.....Y P N
Been treated for alcoholism.....Y P N
Use tobacco.....Y P N
How much_____
How long_____

Indicate with an "X" areas of the body where you feel pain, an imbalance and/or disease:



What approach(es) to your health concerns do you seek:

_____ acute, symptomatic relief
_____ Comprehensive health care
_____ Prevention education

Specifically, what results do you expect for your condition(s)?

_____
_____
_____
_____

How long do you anticipate treatment in order to achieve these results? (Number of days, months, years,)

_____
_____

Rate your motivation to make lifestyle and/or diet changes?

Low Medium High

COLVILLE NATUROPATHIC CLINIC P.S.

No Show/Cancellation Policy

I understand that I will be charged and responsible for a $35.00 fee, which will not be covered by my insurance, if I do not show up for my scheduled appointment. We understand that unforeseen circumstances arise and request that you inform our office 24 hours in advance, in order to avoid the $35.00 fee, so that we may better accommodate other patients.

Patient/Guardian Signature _____

Date _____

//*/

Colville Naturopathic Clinic P.S.

Randy Sandaine, N.D.

NEW PATIENT INFORMATION FORM Date_____

Patient's Last Name _____ First_____ Middle_____

Age_____ Date of Birth _____ Social Security #_____

Mailing Address_____

City_____ State _____Zip Code_____ Marital Status _____

Email Address_____

Home Phone_____ Business Phone_____ Cell Phone _____

Occupation _____Employer's Name_____

Employer Address _____

Spouse (or parent) _____ Telephone #_____

How did you hear about our clinic: ☐ Radio ☐ Newspaper ☐ Referred by: _____

FINANCIAL RESPONSIBILITY

☐ **Check here if same as above**

Last Name_____First_____Middle_____

Date of Birth_____ Social Security #_____

Address_____

City_____ State_____ Zip Code_____

Relationship to patient_____ Home Phone_____ Work Phone_____

Employer's Name _____ Address_____

INSURANCE INFORMATION

Subscriber Name_____ Relationship to Patient_____

Subscriber Date of Birth _____ Does this plan have an HSA or HRA? _____

Name of Insurance_____ Policy ID#_____

Name of Employer Providing Insurance_____

Insurance Phone #_____ Referring Doctor_____

In case of emergency please notify _____ Relationship_____ Phone_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by Colville Naturopathic Clinic P.S.. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Colville Naturopathic Clinic P.S. should they elect to receive such payment.

I have read and fully understand that above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient/Guardian Signature _____ Date_____

Name:_____ Date of Birth _____

Who can we share your medical information with?

I authorize the release of my information from the Colville Naturopathic Clinic P.S. including diagnosis, records, appointments, and billing information to the **following family and friends** (Please do not list medical providers. This is not a medical records release.):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Contact Information/Messages

I authorize the Colville Naturopathic Clinic P.S. to contact me via the following methods.

For appointment reminders please: [ ] Text [ ] Call #_____

Preferred method of contact for other information: _____

Home _____ work _____

Cell _____ Text to cell [ ] Yes [ ] No

Email _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to call you back

If my contact information should change at any time, I understand that it is my responsibility to notify the Colville Naturopathic Clinic P.S. of such changes in order to continue communication.

Patient/Guardian: _____ Date: _____

Notice of Privacy Practices

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create record of the care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Changes to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information:

This is how we use and disclose your medical information: Note: We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose this information about you to doctors, nurses, technicians, medical students or other people who are trying to take care of you.

> **Example:** You are in the hospital with a broken leg. You also have diabetes, a number of health care and support staff need to know about your diabetes during your stay.
> The doctor treating you for your broken leg needs to know if you have diabetes because it may slow the healing process.
> The dietician needs to know about your disease in order to arrange proper meals.
> The pharmacy needs to know about possible medications you are taking as a diabetic.
> The information about your diabetes may help in diagnosing, testing, and X-Ray work.

We may also share medical information about you with other health care providers to assist them in treating you.

For Payment:

We may disclose your medical information for payment purposes.

> **Example:** You are treated in the hospital for a broken leg. We may need to give your health insurance plan information about surgery you received at our organization so that your health plan will pay us or repay you for any surgery that you paid for.
> We may also tell your health plan about a treatment you are going to receive in order to get approval or to determine if your plan will pay for the treatment

Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses, and credentials we need to serve you.

Additional Uses:

In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose your medical information for the following purposes. We may disclose this information to members of the clergy or, except or your religious affiliation, to other who contact us and ask for information about you by:

Funeral Director, Coroner or Medical Examiner:

We may share the medical information about a person who has died with a coroner, medical examiner, funeral director or organ procurement organization to help them carry out their duties.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans for national security and intelligence activities, for protective services for the president and others, for medical suitability determinations for the Department of State, for correctional institutions, and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders, Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, under limited circumstances, such as court order, warrant, or enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with

preventing or controlling a disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration. We may also when authorized by law to do so, notify a person who may have been exposed to communicable disease or otherwise at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety and health of others. We may share your medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped legal custody.

Health Oversight Activities:
We may disclose your medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil administrative, or criminal investigations or proceeding, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes, on our premises, and crimes in emergencies.

Your Individual Rights:
You have a right to:

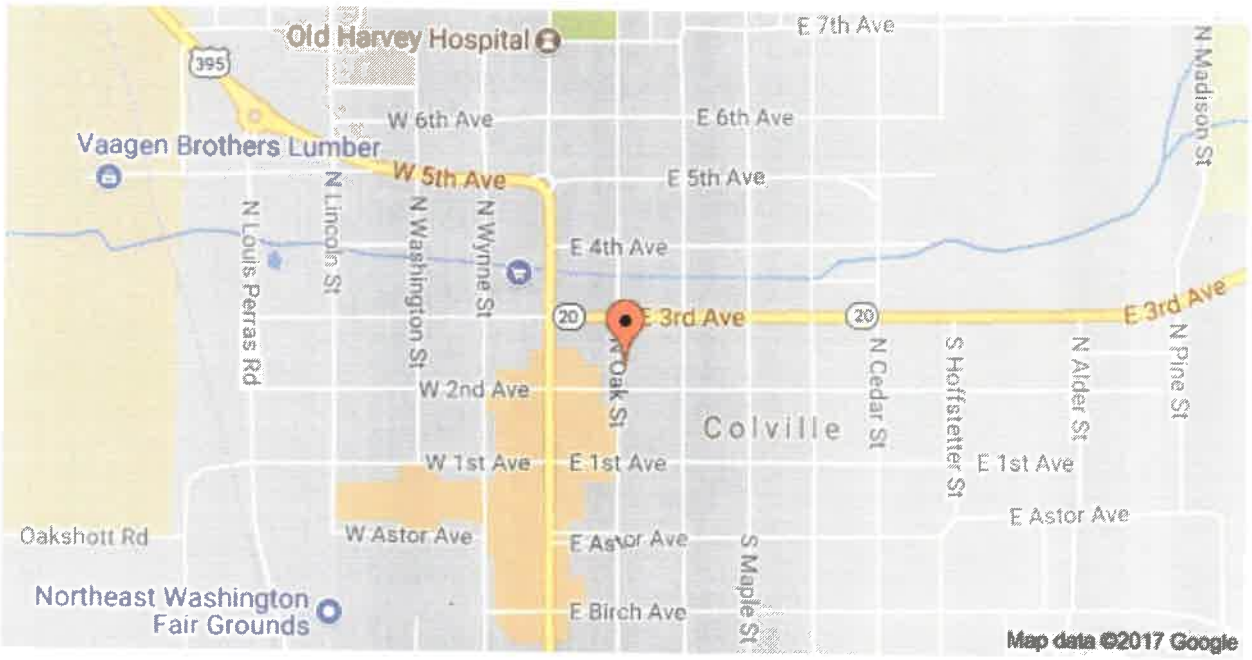
1. Look at or get your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (EXCEPT in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be in writing to our Privacy Officer.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any further sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Sign above that you agree to these terms

Questions and Complaints
If you have any questions about this notice, please ask the receptionist for help or ask to speak to our Privacy Officer. If you think that we may have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with address to file your complaint. We will not retaliate in any way if you choose to file a complaint.
These privacy practices are in effect and will remain in effect until further notice.

DRIVING DIRECTIONS:

Colville Naturopathic Clinic, PS
234 N. Oak
Colville, WA 99114
(509)684-1104 phone



South Bound (coming from Kettle Falls or north): Travel south on Hwy 395. At the roundabout take first exit to continue on Hwy 395/W 5th Ave. Continue on through the first light. The road will curve around Safeway turning into Main St. At the second light just after Safeway take a left onto E 3rd/Hwy20 (Tiger Hwy). You will then take you next right onto North Oak Street. We will be the third building on your left.

North Bound (coming from Chewelah or south): Travel north on Hwy 395. At the roundabout take the second exit to continue on Hwy 395/Main St. Continue on Main St. until you reach the stop light for the intersection of Main & 3rd. Take a Right onto E. 3rd Ave/Hwy 20 (Tiger Hwy). You will then take your next right onto North Oak Street. We will be the third building on your left.