Evergreen Natural Health Center
6610 SW Capitol Hwy • Portland OR, 97239
503-977-0500 • HealthyPDX.com

PATIENT INFORMATION SHEET

PATIENT:

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

Gender: M F Date of Birth: ____ / ____ / _____ Age: _____ SS#: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

We will use your email for appt reminders as well as for Dr. Brody's health updates. You can unsubscribe at any time.

Employer Name: _____ Occupation: _____

Work Address: _____

Relationship status: Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___ Single ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Other ___

How did you hear about our clinic? _____

SPOUSE/PARTNER OR GUARDIAN: *Please circle one.*

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

Phone: (h) _____ (w) _____ (c) _____

Do you live at the same address? Y N

EMERGENCY: *Name and address of nearest relative or friend* **not living with you**:

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

Phone: (h) _____ (w) _____ (c) _____

Relationship to Patient: _____

INSURANCE: *Please present your insurance card(s) to the receptionist.*

Insured's Name: _____ Insured's date of birth: ____ / ____ / _____

RESPONSIBLE PARTY: *Fill out if you are not the patient but are responsible for the bill.*

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you?_____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____

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Today's date: _____

Patient Information:

Legal Name First: _____ Last: _____

I prefer to be called: _____ Date of Birth: _____

Medical History:

Currently, what are your most important health concerns?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you currently receiving health care? Yes / No

If yes, where, and from whom? _____

If no, when, where, and why did you last receive health care? _____

_____

Medication History:

Please list type and dosage of any prescription or over the counter medications, vitamins or other supplements you are currently taking. Please attach a list if necessary.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list type, dosage and time frame for any prescription or over the counter medication you have regularly taken in the past. (ex: steroid 2x/day- asthma 1972-1976, advil- back pain 1997-1999.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication Allergies: _____

X-rays and Special Studies:

If you have had any imaging studies (x-ray, ultra sound, MRI, DEXA etc) or special testing done list the test, approximate date, and outcome.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Injuries/Surgeries, Hospitalizations: Please list type of surgery and approximate date.

1. _____ 3. _____
2. _____ 4. _____

INITIAL HERE _____

Immunizations:

Are there any recommended immunizations you have not had? _____

Have you ever had an adverse (bad) reaction to an immunization? Y / N

Which childhood diseases have you had? Ex. measles, chicken pox etc.

_____

_____

Family Medical History: IF KNOWN. (If you were adopted, please check here: _____)

Please specify M=mother, F=father, S=sister, B=brother A=aunt, U=uncle, PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies or hay fever _____ High Cholesterol _____

Arthritis _____ Cancer _____

Heart Attack _____ Diabetes _____

High blood pressure _____ Other _____

Review of Systems: *Although this section is lengthy, it assures that as much time as needed during the visit to address current concerns. It also allows the physician to make possible connection between symptoms that have not been noted before. Thank you for your patience.*

Please circle: Y = current condition, N = never had this condition, P = past condition

Emotional

History of counseling	Y	N	P	Eating disorder	Y	N	P
Mood swings or depression	Y	N	P	Anxiety	Y	N	P
Considered/attempted suicide	Y	N	P	Tension or nervousness	Y	N	P

Endocrine

Thyroid problems	Y	N	P	Heat or cold intolerance	Y	N	P
High blood sugar	Y	N	P	Diabetes	Y	N	P
Low blood sugar	Y	N	P	Excessive thirst or hunger	Y	N	P

Neurologic

Seizures	Y	N	P	Loss of balance	Y	N	P
Muscle weakness	Y	N	P	Vertigo or dizziness	Y	N	P
Loss of memory	Y	N	P	Numbness or tingling	Y	N	P
Paralysis	Y	N	P	Fainting	Y	N	P

Nose and Sinuses

Sinus pain	Y	N	P	Post nasal drip	Y	N	P
Sinus infection	Y	N	P	Chronic stuffy nose	Y	N	P
Hay fever/ nasal allergies	Y	N	P	Loss of smell	Y	N	P

Eyes/Ears

Floaters/ spots	Y	N	P	Eye pain/strain	Y	N	P
Corrective lenses	Y	N	P	Tearing or dryness	Y	N	P
Blurriness or double vision	Y	N	P	Glaucoma or cataracts	Y	N	P
Hearing impairment	Y	N	P	Ringing in ears	Y	N	P
Excessive ear wax	Y	N	P	Pain in ears	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P	Hoarse voice	Y	N	P
Grinding teeth: awake or asleep	Y	N	P	Excess saliva or dry mouth	Y	N	P
Gum problems	Y	N	P	Mouth sores: inside or out	Y	N	P

Respiratory

Cough	Y	N	P	Shortness of breath	Y	N	P
Tuberculosis	Y	N	P	Wheezing or Asthma	Y	N	P
Pain with breathing	Y	N	P	Bronchitis	Y	N	P

Urinary/Kidney

Painful urination	Y	N	P	Inability to hold urine	Y	N	P
Increased frequency (day or night)	Y	N	P	Kidney stones	Y	N	P
Urgency	Y	N	P	Urinary tract infections	Y	N	P

Skin

Rashes/eczema	Y	N	P	Lumps	Y	N	P
Acne or boils	Y	N	P	Itching or fungus	Y	N	P
Color Change	Y	N	P	Psoriasis	Y	N	P

Head

Headaches	Y	N	P	TMJ issues	Y	N	P
Head Injury	Y	N	P				

Cardiovascular

Heart Disease	Y	N	P	Problems with veins	Y	N	P
Murmur or valve problems	Y	N	P	Chest Pain	Y	N	P
Blood Clots	Y	N	P	High Blood pressure	Y	N	P
Palpitations or fluttering	Y	N	P	Low blood pressure	Y	N	P

Gastrointestinal

Trouble swallowing	Y	N	P	Change in bowel habits	Y	N	P
Liver disease	Y	N	P	Change in appetite	Y	N	P
Nausea or vomiting	Y	N	P	Heartburn or ulcer	Y	N	P
Pain or cramps	Y	N	P	Diarrhea	Y	N	P
Black, green, or white stool	Y	N	P	Constipation	Y	N	P
Hemorrhoids or blood in toilet	Y	N	P	Gallbladder disease	Y	N	P
How often do you have a bowel movement?							

INITIAL HERE _____

Immune

Chronic Fatigue Syndrome	Y	N	P	Get sick often	Y	N	P
Chronically swollen glands	Y	N	P	Autoimmune disease	Y	N	P
Slow wound healing	Y	N	P	Frequent infections	Y	N	P

General Reproductive

Are you sexually active?	Y	N	P	Sexual orientation			
Chlamydia or gonorrhea	Y	N	P	Low sex drive	Y	N	P
Herpes	Y	N	P	Genital warts	Y	N	P
Type of contraception (if applicable)							
Have you been recently tested for sexually transmitted diseases?							
Would you like to be tested for sexually transmitted diseases?							

Female Reproductive

Sexual orientation				Are you still menstruating	Y	N	
Regular menstrual cycles (timing)	Y	N	P	First day of last menstrual cycle			
How many days between the first day of one cycle and the first day of the next cycle?							
How many days of bleeding (typically)?							
Pain or cramps	Y	N	P	PMS	Y	N	P
Clotting	Y	N	P	Heavy flow	Y	N	P
Abnormal pap smear	Y	N	P	Endometriosis	Y	N	P
Ovarian cysts	Y	N	P	Yeast infection	Y	N	P
Menopausal symptoms	Y	N	P	Vaginitis (gardnerella or BV)	Y	N	P
Nipple discharge	Y	N	P	Breast pain	Y	N	P
Have you adopted any children?	Y	N		Monthly self breast exam?	Y	N	P
# pregnancies	# abortions			# miscarriages	# live births		

Male reproductive

Hernia	Y	N	P	Testicle pain	Y	N	P
Premature ejaculation	Y	N	P	Testicle lump	Y	N	P
Prostate problems	Y	N	P	Impotence	Y	N	P

Musculoskeletal

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Muscle pain, spasm, or cramping	Y	N	P
Low bone density	Y	N	P	Nerve pain	Y	N	P

Other

Cancer	Y	N	P	Anemia	Y	N	P
Bruising	Y	N	P	Swelling	Y	N	P
Any other condition/s not mentioned?							

INITIAL HERE _____

Habits

Main interests and hobbies:							
Regular exercise	Y	N	P	Hours of exercise per week			
Quality sleep	Y	N	P	Average hours of sleep per night			
Enjoyable work	Y	N	P	Is your work stressful?	Y	N	
Spiritual practice	Y	N	P	Type of spiritual practice?			
How much TV do you watch daily?				Physical or sexual abuse	Y	N	P
Regular vacations	Y	N		Supportive relationship	Y	N	
Recreational drugs	Y	N	P	Personal history of addiction	Y	N	
Do you think you're overweight?	Y	N		Do you think you're underweight?	Y	N	
Cups coffee per day:	Cups tea per day:			Amt of soda per day:			
How much water do you drink on an average day?				Tap / Filtered / Bottled			
Food intolerances (if known):							

A few final questions:

1. How does your current state of health affect your day to day life?

_____

_____

_____

_____

2. How would your life be different if you felt 100%?

_____

_____

_____

_____

For questions 3 and 4, please use a scale of 1 to 10.

3. How committed are you to improving your health? _____

4. How much change are you willing to make at this time for improving your health? _____

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease." –Thomas Edison

INITIAL HERE _____

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Consent to Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) at Evergreen Natural Health Center. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, bleeding, pain, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha and an occasional side effect of needle insertion. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided. I will notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that there may be other treatment options and that acupuncture is not a required procedure.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures for my present condition and for any future condition(s) for which I seek treatment, realizing that no guarantees have been given to me regarding cure or improvement.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

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Insurance & Financial Policies
PLEASE READ THOROUGLY AND INITIAL BELOW

If you have questions about any of our financial policies please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

Insurance:
In many cases we will be able to call to verify your coverage during your first visit. **If benefits cannot be determined at the time of service and/or if there is any doubt regarding your coverage, payment in full is expected.** If your insurance company remits payment you will be reimbursed when we receive payment. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does *not* guarantee payment as it is possible for an insurance company to misquote coverage. We strongly recommend reviewing your policy to confirm that the information we received is correct. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your policy.
Initial here _____

It is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days). If we are having trouble getting payment within this time frame and you would like us to continue to pursue billing your insurance company, we will require payment for the visit, verbal confirmation from you, and a $15 per claim fee in order to help defray the costs of completing the payment. ***Initial here*** _____

Supplements:
Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are happy to take a return if the safety seal has not been broken, and it is within 60 days of date of purchase. **Please note that there is no requirement to purchase supplements from our office; there are several local stores or web stores that may carry similar products**. ***Initial here*** _____

Late Cancellation/Missed Appointments:
There will be a $50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice. After two missed appointments in a calendar year, you will be charged for the entire time reserved for you on the schedule. If you are scheduled for naturopathic and acupuncture on one day, this is considered two appointments as two slots have been reserved on the schedule. Please note that we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies. ***Initial here*** _____

Methods of Payment:
We accept cash, checks, debit, Visa, and MasterCard. There is a $25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made.

Authorizations:
• I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.

• I authorize the release of any medical or other information necessary to process any claims.
• I authorize payment of benefits to Evergreen Natural Health Center for all services rendered.

Patient's or Authorized Person's Signature:

Name (please print): _____

Signature:_____ Date: _____

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PATIENT NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.

Patient Rights, Uses and Disclosures of Health Information:
During the course of your care with Evergreen Natural Health Center we may use or disclose personal and health-related information.

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

Physician Legal Duties:
We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

Complaints and Questions:
If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact us at 503.977.0500. This notice and any alterations or amendments will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____
Patient Name (please print) Signature Date

If patient is a minor, or if patient is being represented by another party, your representative signs below:

_____ _____ _____
Personal Representative (please print) Personal Representative Signature Date