

BEAVERTON NATUROPATHIC MEDICINE, LLC

4085 SW 109TH AVENUE, SUITE 200 BEAVERTON, OR. 97005

PHONE: 503.643.1024 FAX: 503.644.1293

Date _____

Patient Information

Patient Name _____					
	Last Name	First Name	Middle Initial		
Street Address _____					
City _____	State _____	Zip Code _____			
Home Phone _____		Work Phone _____			
Cell _____		E-mail _____			
You can leave messages pertaining to my health at my: Home Work Cell					
Birth Date _____		Patient's SS # _____			
Single	Married	Widowed	Divorced	Sex M / F	Age _____
Occupation _____		Full-time	Part-Time		
Emergency Contact _____		Relationship _____			
Home # _____		Cell / Work # _____			
How did you hear about this clinic? _____					
Do you have any spiritual / religious affiliations? _____					

Reason For Visit

Other Health Issues You Are Concerned With

Allergies

Medications

Supplements

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What Are Your Most Important Health Concerns?

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

Are you currently receiving healthcare? **Y** **N**

If Yes, then from whom? _____

If No, when was the last time you received health care? _____

Please List All Hospitalizations and Surgeries Including Approximate Date

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

Current Weight _____ Current Height _____
Maximum Weight _____ Minimum Weight _____

Immunizations

Please circle all immunizations you have had:

Polio	Pertussis
Tetanus	Diphtheria
Measles / Mumps / Rubella	Other _____

Family History

Please list any members of your family such as parents, grandparents, or siblings who may have had any of the following conditions:

Cancer _____	Asthma / Allergies _____
Diabetes _____	Anemia _____
Heart Disease _____	Kidney Disease _____
High Blood Pressure _____	Glaucoma _____
Stroke _____	Tuberculosis _____
Epilepsy _____	Mental Illness _____
Other _____	Other _____

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Review of Systems

Do you use alcohol?	Yes	No	How much / how often? _____
Do you use tobacco?	Yes	No	How much / how often? _____
Do you drink coffee?	Yes	No	How much / how often? _____
Do you exercise?	Yes	No	How much / how often? _____

Symptoms – please place a check by all current conditions or symptoms

<input type="checkbox"/> Mood swings	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Rashes
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Vertigo or dizziness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Head injury	<input type="checkbox"/> TMJ	<input type="checkbox"/> Pain in, or stiff neck
<input type="checkbox"/> Changes in vision	<input type="checkbox"/> Recurrent or chronic infections	
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Frequent sore throats
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Nasal stuffiness
<input type="checkbox"/> Lumps or goiter in neck	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cold hands or feet
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Cough up sputum	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Shortness of breath / lying
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Angina / Chest pain	<input type="checkbox"/> Trouble swallowing
<input type="checkbox"/> High / low blood pressure	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Ankle swelling
<input type="checkbox"/> Palpitations / fluttering	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Easy bleeding or bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Deep leg pain	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea / vomiting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Blood in stool / black stool
<input type="checkbox"/> Constipation	<input type="checkbox"/> Pain with bowel movements	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Gall bladder removal	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Increased urinary frequency	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Increased frequency at night	<input type="checkbox"/> Frequent urinary tract infections	
<input type="checkbox"/> Inability to hold urine	<input type="checkbox"/> Joint pain or stiffness	<input type="checkbox"/> Muscle spasms or cramps
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Sexually transmitted disease

Are you sexually active? **Y N**

Female Specific Symptoms

<input type="checkbox"/> Irregular menstrual cycles	<input type="checkbox"/> Bleeding between cycles	<input type="checkbox"/> PMS
<input type="checkbox"/> Painful menses	<input type="checkbox"/> Pain with intercourse	<input type="checkbox"/> Menopausal symptoms
<input type="checkbox"/> Breast pain / tenderness	<input type="checkbox"/> Heavy or excessive flow	<input type="checkbox"/> Breast lumps or discharge
Number of pregnancies _____	Number of live births _____	Age of first menses _____
Number of miscarriages _____	Number of abortions _____	Age of last menses _____
Duration of menses _____	Length of cycle _____	

Male Specific Symptoms

<input type="checkbox"/> Testicular pain or masses	<input type="checkbox"/> Prostate disease	<input type="checkbox"/> Premature ejaculation
<input type="checkbox"/> Erectile dysfunction		

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Financial Information

Responsible Party: Self Spouse Parent Other: _____

Responsible Party (if not self): _____

Responsible Party's SS # _____ Birth Date: _____

Do you have Naturopathic Benefits? YES / NO

If No

I, the undersigned, understand that payment is due in full at the time of the services rendered, unless other arrangements for payment have been discussed. I also understand that I am financially responsible for all charges incurred.

Signature _____ Date: _____

If Yes

If you have naturopathic benefits on your insurance plan we would be happy to bill your insurance for your visits, but we request that you please verify your benefits and fill out the **Insurance Benefits Form**. You can find this form on our website www.beavertonnaturopathicmedicine.com or from our front desk staff.

Assignment of Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for myself, and / or dependents, and that I will be bound to this signature as though the undersigned had personally signed the particular claim. Beaverton Naturopathic Medicine represents any physician contracted to practice at the clinic of Beaverton Naturopathic Medicine. I hereby authorize all of my insurance claims to pay and hereby assign directly to Beaverton Naturopathic Medicine all benefits, if any, otherwise payable to me for his / her services. I understand I am financially responsible for all charges incurred.

Signature _____ Date: _____

Consent to Treat

I have been informed and understand that:

1. Any treatment or advice provided to me as a patient of Beaverton Naturopathic Medicine is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider
2. I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider and no physician or staff member is recommending that I refrain from seeking or following the advice of another licensed health care provider.
3. The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider.

Signature _____ Date: _____

Judy E. Peabody, ND _ Chris D. Meletis, ND _ James F. Hermes, ND _ Sara G. Wood, ND

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Beaverton Naturopathic Medicine Clinic LLC

As required by the privacy regulations, I hereby acknowledge that I have read and / or received a copy of Beaverton Naturopathic Medicine Clinic LLC's "NOTICE OF PRIVACY PRACTICES" revised 5-1-08. This document is available for review on the website at www.beavertonnaturopathicmedicine.com or in the office.

As required by the Privacy Regulations, I am aware that Beaverton Naturopathic Medicine Clinic, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office is not required to honor any changes to the Notice of Privacy Practices. By way of my signature, I provide Beaverton Naturopathic Medicine Clinic, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

Signature _____ Date: _____

Print Name _____

OFFICE USE ONLY

Signed form received by: _____

Date Received: _____