Patient Information Form

BASTYR CENTER FOR NATURAL HEALTH | *the teaching clinic of Bastyr University*

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

Preferred Name: _____ SS#: _____ - _____ - _____

Date of Birth *(required)*: _____ / _____ / _____ Sex at Birth: _____

Address: _____ Unit #: _____ City: _____

State: _____ ZIP: _____ Email: _____

Other name(s) that records may be kept under: _____

Phone

Appointment reminders will be send to 1st preference

1. ☐ Home ☐ Work ☐ Cell (_____) _____ 2. ☐ Home ☐ Work ☐ Cell (_____) _____

***Confidential voicemails OK?** ☐ Yes ☐ No ***Confidential voicemails OK?** ☐ Yes ☐ No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Are you currently employed? ☐ No ☐ Yes Employee/Address: _____

Are you a Bastyr employee or student, or significant other of one? ☐ No ☐ Yes Please specify: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ Date of Birth *(required)*: _____ / _____ / _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ Date of Birth *(required)*: _____ / _____ / _____

Please check below if applicable

☐ Auto Accident ☐ Workers Compensation Date of accident or injury: _____ Claim #: _____

Parent/Guardian/Information

To be filled out if patient is a minor, or if someone other than the patient is medically and financially responsible for the patient.

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

Legal Guardian? ☐ Yes ☐ No Date of Birth *(required)*: _____ / _____ / _____

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

Legal Guardian? ☐ Yes ☐ No Date of Birth *(required)*: _____ / _____ / _____

Other Legal Guardian Name: _____

Relationship to Patient: _____ Date of Birth *(required)*: _____ / _____ / _____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient Signature (*18 and older*): _____ Date _____ / _____ / _____

Parent/Guardian Signature : _____ Date _____ / _____ / _____

Last Revised Sept. 2017

Patient Information Form

Demographic Data Collection

Bastyr is committed to providing quality care for all patients. We are asking you to provide your marital status; your racial and ethnic background; the language you prefer to use when speaking with your doctor; and whether you are or were military. Your answers are both voluntary and private. Thank you for your cooperation.

What is your marital status?

☐ Single ☐ Married ☐ Significant other ☐ Widowed

Do you consider yourself Hispanic or Latino? Please check one:

☐ I AM Hispanic or Latino ☐ I don't know

☐ I am NOT Hispanic or Latino ☐ Decline to answer

Which category best describes your race? You may circle one or more:

☐ White or Caucasian ☐ American Indian ☐ Other race

☐ Black or African American ☐ Alaskan Native ☐ I don't know

☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Decline to answer

What is your preferred language when speaking with your doctor?

☐ English ☐ Other (please specify): _____

Do you need an interpreter? ☐ Yes ☐ No

Are you active military or veteran?

☐ Yes

☐ No

☐ Decline to answer

How did you hear about us?

☐ Friend/Patient ☐ External Referral ☐ Walk By

☐ Event/Health Fair ☐ Staff/Student ☐ Website: _____

☐ Shuttle/Bus ☐ Current Patient ☐ Social Media

☐ Physician/Specialist ☐ Radio/TV ☐ Yelp

☐ Please sign me up for Clinic newsletter so I can stay up to date regarding clinic hours, events and discounts.

☐ Research is vital to advancing Naturopathic Medicine. Please check if you'd be interested in participating in a relevant study.

PSR initials: _____

Patient Profile

Patient name: _____ Date of Birth ____ / ____ / ____

Preferred name: _____ Sex at Birth: _____

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

What goals do you have for your visit at the clinic today?

_____

_____

Who is your Primary Care Provider?_____Phone: (____) _____

Please list other providers/specialists involved in your care and their clinic phone number:

_____

_____

If you are seeking adjunctive cancer support, who is your oncologist?

Oncologist?_____Phone: (____) _____

When was your last physical? _____ When did you last have bloodwork?_____

Please indicate the type of care you are seeking

☐ Primary management of my health ☐ Adjunctive care for my health

☐ Ongoing management of my health ☐ One time advice for my health

☐ I don't know at this time

Have you ever consulted a Naturopathic or Ayurvedic Physician, Acupuncturist, Nutritionist or Counselor before?

☐ Yes ☐ No

If YES, please circle which type of practitioner you've previously consulted with.

In general would you say your health today is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Social History

Do you consume alcohol?: ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you use cannabis?: ☐ Yes ☐ No If yes, for _____ medicinal or _____recreation use, or _____ both

How often do you use cannabis in a given week? _____In what forms?: _____

Other drug usage, past or present:_____

Current or past tobacco use: Amount/packs per day:_____ How long: _____Quit date: _____

Do you have children? ☐ Yes ☐ No If yes, what are their ages: _____

Do you exercise regularly? ☐Yes ☐No If yes, please describe type of exercise and how often below:

_____

Patient Profile

Patient name: _____ Date of Birth _____/_____/_____

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition (MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather).

Condition	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF
Allergies								
Anemia								
Anxiety								
Arthritis								
Asthma								
Blood transfusion								
Cancer								
Cataracts								
Congestive heart failure								
Clotting disorder								
COPD								
Depression								
Diabetes								
Emphysema								
GERD								
Glaucoma								
Heart attack								
Heart murmur								
HIV/AIDS								
Hypertension								
Irritable bowel syndrome								
Kidney disease								
Meningitis								
Nerve/muscle disease								
Osteoporosis								
Parkinson's/Alzheimer's								
Seizures								
Sickle cell anemia								
Stroke								
Substance abuse								
Thyroid disease								
Tuberculosis								
Ulcers								
Other								
Other								

Patient Profile

Patient name: _____ Date of Birth _____ / _____ / _____

Medical History

Do you have any **medication allergies or any allergic reactions** to anything else? ☐ Yes ☐ No

If **yes,** please explain: _____

_____

Do you have an Epi Pen for severe allergic reactions? ☐ Yes ☐ No ☐ N/A Expiration date: _____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

Name of medication/supplements *(such as Synthroid, Vitamin D, etc.)*	**Strength** *(88mcg, etc.)*	**Directions** *(such as 1 tablet twice a day, as needed, etc.)*
☐ Check if none		

Description of other pertinent medical history (self or family): _____

_____

Were you born via: ☐ Vaginal delivery ☐ C-section Were you: ☐ Breast-fed ☐ Formula-fed

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization: *Date:*

_____ _____ / _____ / _____

_____ _____ / _____ / _____

_____ _____ / _____ / _____

_____ _____ / _____ / _____

_____ _____ / _____ / _____

Holistic Health Assessment

Patient name: _____ Date of Birth _____ / _____ / _____

In order to complete a Holistic Health Assessment, please answer the following questions:

Digestion

Please check any issues you have with digestive function: ☐ None

☐ Gas, bloating, flatulence, burping ☐ Mild ☐ Moderate ☐ Severe

☐ Abdominal pain or cramping ☐ Mild ☐ Moderate ☐ Severe

How often do you have a bowel movement? _____ times per day/week (circle)

Please check all that apply about your bowel movements:

☐ Difficult to pass ☐ Contain undigested food ☐ Small and hard ☐ Formed
☐ Loose ☐ Fatty or oily ☐ Contains blood ☐ Easy to pass
☐ Diarrhea ☐ Incomplete ☐ Dark in color/tar-like ☐ Feels complete

How often have you taken antibiotics in your life: ☐ Never ☐ Rarely ☐Sometimes ☐ Often

When was the last dose of antibiotics taken:_____

Have you traveled outside the country? If so, where and when?:_____

_____

Have you ever had food poisoning? If so, when?: _____

Please check any that apply to you:

☐ Celiac disease ☐ Diverticulosis or diverticulitis ☐ Irritable bowel syndrome (IBS) ☐ Small intestine bacteria overgrowth (SIBO)
☐ Crohn's disease ☐ Gingivitis ☐ Missing teeth ☐ Swollen gums
☐ Difficulty chewing ☐ Heartburn or GERD ☐ Oral allergy syndrome ☐ Ulcerative colitis
☐ Difficulty swallowing ☐ Hiatial hernia

Immune Defense and Repair

How often do you get sick? ☐ Rarely ☐Sometimes ☐ Often

Do you feel you get sick more than others around you? ☐ Yes ☐ No

Do you have any chronic inflammatory conditions (arthritis, autoimmune disease, eczema …)?

Please list: _____

Do you heal quickly after injury or surgery? ☐ Yes ☐No ☐ Unsure

Sleep

Do you have any difficulty sleeping? ☐ Yes ☐ No _____

Please check any that apply to you:

☐ Trouble falling asleep ☐ Snoring ☐ Have trouble waking up
☐ Trouble staying asleep / wake frequently ☐ Stop breathing at night ☐ Feel rested in the morning
☐ Night terrors ☐ Use a C-PAP machine ☐ Sleep well generally
☐ Difficulty swallowing ☐ Feel tired in the morning

Circulation

Do you have swelling in any part of your body? ☐ Yes ☐ No If yes, describe _____

Check all that applies: ☐ Varicose veins ☐ Spider veins ☐ Cold hands and feet

Holistic Health Assessment

Patient name: _____ Date of Birth _____/_____/_____

Biotransformation and Elimination

Are you routinely exposed to any chemicals through your living situation, recreation or work (solvents, pesticides, cigarette smoke…)? ☐ Yes ☐ No ☐ Unsure If yes, please describe: _____

Check all that you are sensitive to: ☐ Caffeine ☐ Perfume ☐ Cigarette smoke ☐ Other _____

Check all that apply to you:

☐ Lived on a farm or where any agricultural or insect-controlling chemicals were
☐ Lived in a home built prior to 1975
☐ Ate fish, mollusks or crustaceans more than twice a week
☐ Worked in any industry where you could smell chemicals
☐ Have had any significant exposure to chemicals you know of
☐ Worked with any toxic metal including dentistry
☐ Lived or worked in an area that was or became a Superfund site
☐ Lived or worked where you could see or smell any burning of fuel, metal, rock or wood

Hormone Balance

Check all that apply to you:

☐ Acne
☐ Anxiety
☐ Crave sugar or salt
☐ Depression
☐ Difficulty concentrating
☐ Do not feel rested in the morning
☐ Dry skin
☐ Feel unusually cold or hot
☐ Forgetfulness or memory problems
☐ Hypoglycemia

Females only:

☐ PMS
☐ Unwanted facial hair
☐ Infertility
☐ Menopause
☐ Fibroids
☐ Endometriosis

Structural Integrity

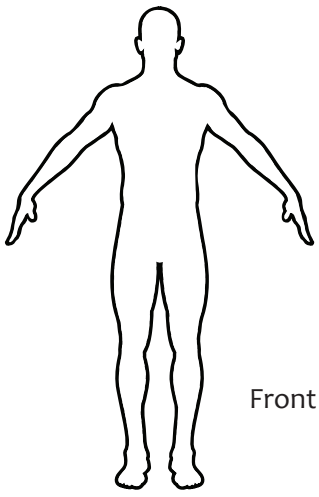
Do you bruise easily? ☐ Yes ☐ No

Do you get headaches? ☐ No ☐ Rarely ☐ Sometimes ☐ Frequently

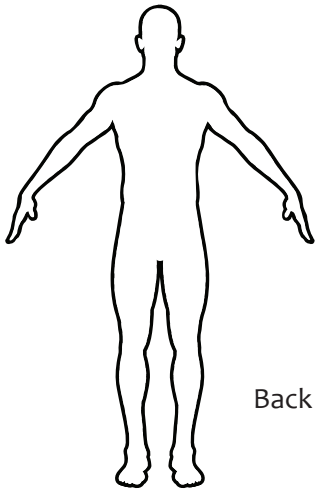
Do you have any skeletal or muscular pain? If so where ? _____

Rate the current intensity of your pain on a scale of 1-10, with 10 being the most intense: _____

Please circle where you feel pain below:



Front



Back

Holistic Health Assessment

Patient name: _____ Date of Birth _____ / _____ / _____

Spiritual/Emotional/Social

Do you have a spiritual practice that you follow: ☐ Yes ☐ No If yes, please list _____

Do you have a good support system in your life (friends, loved ones)? ☐ Fair ☐ Good ☐ Excellent

With whom do you live: _____

What do you dedicate yourself to (work, school, parenting, significant hobbies …):_____

_____

How would you rate your stress level overall: ☐ Low ☐ Medium ☐ High ☐ Extreme

What are your major stressors? _____

What do you do to cope with stress? _____

Signatures

_____ _____

Patient/Guardian (Print Name): **Date**

_____ _____

Patient/Guardian Signature: **Date of birth**

Reviewed by Provider and ready to be scanned to EPIC (Initals): _____ **Date: _____ / _____ / _____**

Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09r	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global10r	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very severe**
Global08r	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global07r	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**