

PSR _____

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BASTYR UNIVERSITY

Patient Registration PLEASE WRITE LEGIBLY

Patient Name: _____
Last Name First Name Middle Initial

What is your preferred first name? (Nickname, Chosen name, etc.) _____

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

DOB (required) _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Phone: *Appointment reminders will be sent to 1st preference.*

1. Cell Home Work: (_____) _____ **Confidential voicemail OK?** Yes No

2. Cell Home Work: (_____) _____ **Confidential voicemail OK?** Yes No

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? Male Female Unknown Another: _____

What gender do you identify as? Male Female Trans Another: _____

What is your pronoun? He She They Another: _____

Primary Language: _____

Marital Status: Single Married Significant other Widowed

Primary Care Provider (PCP) Information (Please select one of the following):

I wish to establish Primary Care with BCNH.

I see BCNH for ancillary/adjunctive care only. My Primary Care Physician (PCP) is: _____

If seeking adjunctive cancer support, who is your oncologist? _____

• Last physical: _____ Date of Last bloodwork: _____

Other providers: _____

Guarantor – If different from the patient (Person who is financially responsible for the account)

Name: _____ Relationship to the patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Legal Guardian? Yes No SSN: _____ Gender: M F DOB: _____

CONTINUED ON BACK

Emergency Contact or Other Guardian/Parent Name: _____

Relationship: _____ Legal Guardian? Yes No

Primary Phone _____ Work Phone _____

Please provide your insurance information below:

Primary Insurance Company: _____ Group # _____

Member ID # _____ Relationship to Subscriber: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Secondary Insurance Company: _____ Group # _____

Member ID # _____ Relationship to Subscriber: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Check if applicable: Auto Accident Workers compensation Date of Accident: _____ Claim#: _____

****Please be prepared to present your insurance card at check-in at each visit****

Employment Status (Check one): Full Time Not Employed Part Time Retired Seasonal

Self-Employed Student (Full Time) Student (Part Time) BCNH Student BCNH Staff/Spouse

Employer _____

Address _____

How did you hear about us?

Friend/patient Event/health fair Shuttle/Bus Staff/student Physician: _____

Radio/TV Walk by Social media Yelp Website: _____

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

Research is vital to the advancement of natural medicine.

Yes! Please contact me for future research participation. If Bastyr has a research study, I can help with:

I certify the above information is true and correct to the best of my knowledge. I 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/Guardian Signature

Date

Demographic Data Collection

Bastyr is committed to providing quality care for all patients. We are asking you to provide your racial and ethnic background and if you are/were military. This information enables us to learn more about the health needs of our community and better design our services to meet those needs. Your answers are both voluntary and private. Thank you for your cooperation.

1. Do you consider yourself Hispanic or Latino? Please circle one.

I AM Hispanic or Latino

I am NOT Hispanic or Latino

I don't know

Decline to Answer

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

Asian

American Indian

Alaska Native

Black or African American

Native Hawaiian

Pacific Islander

White or Caucasian

Other race

I don't know

Decline to answer

3. Active Military or Veteran

Yes or No

Patient initials _____

[Blank page]

Surgeries / Hospitalizations: (Please select all that apply and write in date.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C-Section (If applicable) | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Tubal Ligation (If applicable) |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Hysterectomy (If applicable) | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Vasectomy (If applicable) |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Prostate Surgery (If applicable) | <input type="checkbox"/> Other: |

**Family History: Do you have a family history of any of the following?
(Please "X" the boxes that apply to you)**

	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother															
Father															
Sister															
Brother															
Maternal Grandma															
Maternal Grandpa															
Paternal Grandma															
Paternal Grandpa															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															
Other															

- Adopted Family History Unknown

Social History: Please answer the following questions regarding your social history:

Tobacco Use

Tobacco Use: Never Smoker Former Smoker Passive Smoke Exposure (Second Hand) Current Smoker

Other

Start Date: _____ End Date: _____

Type of tobacco used: Cigarettes Cigars Pipe

Packs/Day: _____ Years: _____

Smokeless Tobacco: Current User Former User Never Used Unknown

Types: Snuff Chew

Quit Date (if applicable): _____

If you are a current tobacco user: Are you ready to quit? Yes No

Do you drink alcohol?

Yes

No

If Yes, how many of the following do you have per week?

Drinks/Week: Glasses of Wine _____ Cans of Beer _____ Shots of Liquor _____

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> E-Cigs | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Opioids | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> PCP | <input type="checkbox"/> Ecstasy |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Ketamine | <input type="checkbox"/> Mescaline | <input type="checkbox"/> Psilocybin |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Crack | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Solvent Inhalants |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> IV | <input type="checkbox"/> Other |

If yes to Marijuana: Medicinal? Recreational? Both?

If yes to any of the drugs above how many times per week estimate do you use them? _____

What is your current birth control method? (Please select all that apply):

Sexually Active: Yes No

Birth Control/Protection:

- | | | | |
|-------------------------------------|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Abstinence | <input type="checkbox"/> Cervical Cap | <input type="checkbox"/> Condom | <input type="checkbox"/> Hormonal Patch |
| <input type="checkbox"/> Implant | <input type="checkbox"/> Injection | <input type="checkbox"/> Inserts | <input type="checkbox"/> IUD |
| <input type="checkbox"/> IUS | <input type="checkbox"/> Pill | <input type="checkbox"/> Rhythm | <input type="checkbox"/> Spermicide |
| <input type="checkbox"/> Sponge | <input type="checkbox"/> Surgical | <input type="checkbox"/> Vaginal Ring | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Menopause | <input type="checkbox"/> None | <input type="checkbox"/> Other |

Partners? Male Female Both Another

Sexual Orientation/Gender Identity (this helps our clinicians give you the best care possible):

What is your birth sex? Male Female Unknown Another: _____

What gender do you identify as? Male Female Trans Another: _____

What is your pronoun? He She They Another: _____

Do you have any children? Yes No If so, what are their ages:

Do you exercise regularly? Yes No If so, how often and what type of exercise?

Do you have any dietary restrictions or food intolerances? Yes No If so, what?

Additional Medications/Supplements?

Name of Medication/Supplement	Dose	Frequency Taken
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Constitutional

Fever	Y	N	Chills	Y	N	Weight Loss	Y	N
Malaise/Fatigue	Y	N	Sweating	Y	N	Weakness	Y	N

Skin

Rash	Y	N	Itching	Y	N	Color changes	Y	N
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Head, Ears, Eyes, Nose, Throat

Headaches	Y	N	Hearing Loss	Y	N	ringing in Ears	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Nosebleeds	Y	N
Congestion	Y	N	Migraine headaches	Y	N	Sore Throat	Y	N

Eyes

Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness	Y	N

Cardiovascular

Chest Pain	Y	N	Palpitations	Y	N	Shortness of breath lying down	Y	N
Claudication	Y	N	Leg Swelling	Y	N	Heart Murmur	Y	N
High blood pressure	Y	N	Blood clots	Y	N	Heart disease	Y	N

Respiratory

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N	Asthma	Y	N

Gastrointestinal

Heartburn	Y	N	Nausea/Vomiting	Y	N	Abdominal Pain	Y	N
Diarrhea	Y	N	Constipation	Y	N	Blood in Stool/black stool	Y	N
How many Bowel Movements per day:			Bloating	Y	N			

Genitourinary

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Flank Pain	Y	N	Incontinence	Y	N

Male Reproductive

Hernias	Y	N	Testicular masses	Y	N	Sexual difficulty	Y	N
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Female Reproductive

Age of first menses:		Age of last menses:		Number of pregnancies:	
Number of live births:		Number of miscarriages:		Number of abortions:	

Musculoskeletal

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle spasms	Y	N

Endocrine/Heme/Allergies

Excessive thirst	Y	N	Env. Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat intolerance	Y	N

Neurological

Dizziness/fainting	Y	N	Loss of memory	Y	N	Tremor/Seizures	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Numbness/tingling	Y	N

Emotional (Psychiatric)

Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N