

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 1<sup>st</sup> preference.*

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

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

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**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.**

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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

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**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: \_\_\_\_\_

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**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: \_\_\_\_\_

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**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\*\***

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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:

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**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 \_\_\_\_\_

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# BASTYR UNIVERSITY

## PERSONAL HEALTH HISTORY for YOUR CLINICAL TEAM

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Last Name First Name Middle Initial

What is the main reason, or goal, for your visit today? \_\_\_\_\_

**Allergies:** Do you have a severe allergy to any of the following? **(Please select all that apply)**

- Sulfa      Penicillin      Aspirin      Codeine      Latex      Sulfites
- Cats      Dogs      Mold      Dust      Bees      Pollen
- Wheat      Shellfish      Peanuts      Eggs      Milk      Soy
- Other \_\_\_\_\_

**Medications:** List all medications, over-the-counter medications, vitamins, or other supplements you are taking.  
**If you need additional space to list medications/supplements, please use page 6 or the back of page 7.**

Name of Medication/Supplement	Dose	Frequency Taken

**Medical Conditions:** Do you currently have or have a history of the following? **(Please select all that apply)**

- Adrenal Disorder
- Anemia
- Anxiety
- Arthritis/Joint Disorder
- Asthma
- Cancer
- COPD
- Depression
- Diabetes Mellitus
- Digestive Problem
- Heart Disease
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Disease
- Stroke
- Thyroid Disease
- Other:

**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

## 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: .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global02	In general, would you say your quality of life is:.....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global03	In general, how would you rate your physical health? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 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.).....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 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? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

**In the past 7 days...**

		<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>						
Global10r	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
		<table border="1"> <thead> <tr> <th><b>None</b></th> <th><b>Mild</b></th> <th><b>Moderate</b></th> <th><b>Severe</b></th> <th><b>Very severe</b></th> </tr> </thead> </table>					<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Very severe</b>	
<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Very severe</b>								
Global08r	How would you rate your fatigue on average? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
Global07r	How would you rate your pain on average? .....	<input type="checkbox"/> 0 No pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Worst pain imaginable